BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

JL	.CHON A	A. IDLIA I II	ICATION IN OR	MAIION	
1.	RESIDENT NAME®				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	GENDER®	1. Male	2. Female		
3.	BIRTHDATE®	Month		Year	
4.	RACE/® ETHNICITY	 Asian/Pacific Black, not of 	Hispanic origin	4. Hispanic 5. White, not of Hispanic oriç	gin
5.	SOCIAL SECURITY® AND MEDICARE NUMBERS® [C in 1st box if non med. no.]	b. Medicare nu	rity Number — — — — — — — — — — — — — — — — — — —	ad insurance number)
6.	FACILITY PROVIDER NO.®	a. State No. b. Federal No.			
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ©				
8.	REASONS FOR ASSESS- MENT	a. Primary reas 1. Admissic 2. Annual a 3. Significal 4. Significal 5. Quarterly 10. Significal 0. NONE C b. Codes for a 1. Medicare 2. Medicare 3. Medicare 4. Medicare 6. Other sta 7. Medicare 6. Medicare 6. Other sta 7. Medicare	nt change in status assessi nt correction of prior full ass y review assessment nt correction of prior quarte	y day 14) ment sessment rly assessment * Medicare PPS or the	ne State
9.	SIGNATURE	S OF PERSO	NS COMPLETING THES	SE ITEMS:	
a. Si	ignatures		Title		Date
b.					Date

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊕ - Koy	itame for	computerized	recident	tracking
\sim = Nev	nems for	computenzea	resident	Hacking

= When box blank, must enter number or letter a. = When letter in box, check if condition applies

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

١.	ENTRY	Date the stay began. Note — Does not include readmission in record w closed at time of temporary discharge to hospital, etc. In such cases, u admission date	
		Month Day Year	
2.	ADMITTED	Private home/apt. with no home health services	
۷.	FROM	Private home/apt. with home health services	
	(AT ENTRY)	Board and care/assisted living/group home Nursing home	
		5. Acute care hospital	
		6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital	
		8. Other	
3.	LIVED ALONE	0. No	
	(PRIOR TO	1. Yes	
_	ENTRY) ZIP CODE OF	2. In other facility	
4.	PRIOR		
	PRIMARY RESIDENCE		
5.	RESIDEN- TIAL	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)	
	HISTORY	Prior stay at this nursing home	
	5 YEARS PRIOR TO		a.
	ENTRY	Stay in other nursing home	b.
		Other residential facility—board and care home, assisted living, group home	c.
		MH/psychiatric setting	d.
		MR/DD setting	е.
		NONE OF ABOVE	f.
6.	LIFETIME	THORE OF THORE	Įī.
	OCCUPA- TION(S)		
	[Put "/"		
	between two occupations]		
7.	EDUCATION	1. No schooling 5. Technical or trade school	
	(Highest	2. 8th grade/less 6. Some college	
	Level Completed)	3.9-11 grades 7. Bachelor's degree 4. High school 8. Graduate degree	
8.	LANGUAGE	(Code for correct response)	
		a. Primary Language	
		0. English 1. Spanish 2. French 3. Other	
		b. If other, specify	
9.	MENTAL	Does resident's RECORD indicate any history of mental retardation,	
	HEALTH HISTORY	mental illness, or developmental disability problem? 0. No 1. Yes	
10.	CONDITIONS	(Check all conditions that are related to MR/DD status that were	
	RELATEDTO MR/DD	manifested before age 22, and are likely to continue indefinitely)	
	RELATEDTO MR/DD STATUS	Manifested before age 22, and are likely to continue indefinitely) Not applicable—no MR/DD (Skip to AB11)	a.
	MR/DD	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition	a.
	MR/DD	Not applicable—no MR/DD (Skip to AB11)	a. b.
	MR/DD	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition	b.
	MR/DD	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome	b. c.
	MR/DD	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism	b. c. d.
	MR/DD	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD	b. c. d.
11.	MR/DD	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy	b. c. d.
11.	MR/DD STATUS DATE BACK-	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD	b. c. d.
11.	MR/DD STATUS	Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD	b. c. d.

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE	(Check all that apply. If all information UNKNOWN, check last box of	nly.)
	(In year prior	CYCLE OF DAILY EVENTS	
	to DATE OF ENTRY	Stays up late at night (e.g., after 9 pm)	a.
	to this nursing	Naps regularly during day (at least 1 hour)	b.
	home, or year last in	Goes out 1+ days a week	c.
	community if now being	Stays busy with hobbies, reading, or fixed daily routine	d.
	admitted from another	Spends most of time alone or watching TV	e.
	nursing home)	Moves independently indoors (with appliances, if used)	f.
		Use of tobacco products at least daily	g.
		NONE OF ABOVE	h.
		EATING PATTERNS	
		Distinct food preferences	i.
		Eats between meals all or most days	j.
		Use of alcoholic beverage(s) at least weekly	k.
		NONE OF ABOVE	l.
		ADL PATTERNS	
		In bedclothes much of day	m.
		Wakens to toilet all or most nights	n.
		Has irregular bowel movement pattern	о.
		Showers for bathing	p.
		Bathing in PM	q.
		NONE OF ABOVE	r.
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	s.
		Usually attends church, temple, synagogue (etc.)	t.
		Finds strength in faith	u.
		Daily animal companion/presence	v.
		Involved in group activities	w.
		NONE OF ABOVE	x.
		UNKNOWN—Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS CO	OMPLETING FACE SE	HEET:	
a. Signature of RN Assessment Coord	linator		Date
b. Signatures	Title	Sections	Date
С.			Date
d.			Date
e.			Date
f.			Date
g.			Date

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING **FULL ASSESSMENT FORM**

(Status in last 7 days, unless other time frame indicated)

. RESID	N A. I	DENTIFICATION	I AND	BACKGROUND INFORM	ATION :	3. MEMORY/ RECALL	(Check all that resident was normally able to recall during last 7 days)
NAI						ABILITY	Current season a.
		a. (First)	b. (Midd	dle Initial) c. (Last) d.	. (Jr/Sr)		Location of own room b. That he/she is in a nursing home
ROC NUMI						4 0000	Staff names/faces c. NONE OF ABOVE are recalled e
					'	4. COGNITIVI SKILLS FO	R
ASSE MEI	NT	a. Last day of MDS obs	servatio.	n period		DAILY DECISION	
REFER DAT						MAKING	only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision
		Month	Day	Year			required 3. SEVERELY IMPAIRED—never/rarely made decisions
		b. Original (0) or correct	ted cop	y of form (enter number of correction)		5. INDICATOR	S (Code for behavior in the last 7 days.) [Note: Accurate assessment
n. DATE REEN				ecent temporary discharge to a hosp sessment or admission if less than s		OF DELIRIUM- PERIODIC	
		Month	Day	Year		DISOR- DERED THINKING AWARENES	Behavior present, not of recent onset Behavior present, over last 7 days appears different from resident's usual functioning (a.g., powerset appears).
i. MARI STAT		Never married Married		dowed 5. Divorced parated		AVAILLIE	a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
RECO	ORD O.						b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
CURR PAYM SOUR FOR STA	MENT RCES N.H.	Medicaid per diem Medicare per diem	a.	k all that apply in last 30 days) VA per diem Self or family pays for full per diem	f.		c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
317	AI	Medicare ancillary part A	b. c.	Medicaid resident liability or Medicare co-payment	h.		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
		Medicare ancillary part B CHAMPUS per diem	d. e.	Private insurance per diem (including co-payment) Other per diem	' <u>i. </u>		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
REAS FO ASSE	SONS OR	a. Primary reason for a 1. Admission asses 2. Annual assessm	ssessm sment (nent			f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
MEI		Significant chang Significant correct	ge in sta ction of p	orior full assessment	•	6. CHANGE II COGNITIVI STATUS	compared to status of 90 days ago (or since last assessment if less than 90 days)
	scharge		urn not a	anticipated			0. No change 1. Improved 2. Deteriorated
assess	sment,	Discharged prior		pleting initial assessment	S	ECTION C.	COMMUNICATION/HEARING PATTERNS
subs	limited set of	Significant correct	ction of p	orior quarterly assessment		1. HEARING	(With hearing appliance, if used)
MDS i need compl	d be	1. Medicare 5 day a	nents re	equired for Medicare PPS or the State	е		HEARS ADEQUATELY—normal talk, TV, phone MINIMAL DIFFICULTY when not in quiet setting HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly
		2 Medicare 30 day 3. Medicare 60 day	assess	ment			3. HIGHLY IMPAIRED/absence of useful hearing
		4. Medicare 90 day	assess	ment		2. COMMUNI CATION) · · · · · · · · · · · · · · · · · · ·
		5. Medicare readm 6. Other state requi				DEVICES	, realing aid, present and used
		7. Medicare 14 day 8. Other Medicare	assess	ment		TECH- NIQUES	Hearing aid, present and not used regularly Other receptive comm. techniques used (e.g., lip reading)
RESPO	ONSL	(Check all that apply)	equired	Durable power attorney/financial		12020	NONE OF ABOVE
BILI	ITY/	Legal guardian	_	1	d. :	3. MODES O	(Check all used by resident to make needs known)
LEG GUAR	GAL RDIAN	Other legal oversight	a. b.	Family member responsible	е.	EXPRESSIO	Speech Speech Speech
		Durable power of	D.	Patient responsible for self	f.		Writing messages to Communication board
ADVAN		attorney/health care	c.	NONE OF ABOVE ng documentation in the medical	g.		express or clarify needs b. Other
DIREC	TIVES	record, check all that a	apply)	_			American sign language or Braille c. NONE OF ABOVE
		Living will	a.	Feeding restrictions	f.	4. MAKING	(Expressing information content—however able)
		Do not resuscitate Do not hospitalize	b.	Medication restrictions	g.	SELF UNDER-	UNDERSTOOD USUALLY UNDERSTOOD—difficulty finding words or finishing
		DO NOT NOSPITALIZE	c. d.	Other treatment restrictions	h.	STOOD	thoughts
		Organ donation					2. SOMETIMES UNDERSTOOD—ability is limited to making concrete
		Organ donation Autopsy request	e.	NONE OF ABOVE	i		requests
				NONE OF ABOVE	<u>i.</u>	S SDEECH	3. RARELY/NEVER UNDERSTOOD
		Autopsy request COGNITIVE PAT	e. TERI	NS	i	5. SPEECH CLARITY	3. RARELY/NEVER UNDERSTOOD (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words
		Autopsy request COGNITIVE PAT	e. TERI	NS discernible consciousness)		CLARITY	3. RARELY/NEVER UNDERSTOOD (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words
	ATOSE	Autopsy request COGNITIVE PAT (Persistent vegetative second	e. TERI state/no 1.Yes	NS discernible consciousness) (If yes, skip to Section G)		6. ABILITYTO UNDER-	3. RARELY/NEVER UNDERSTOOD (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words 0 (Understanding verbal information content—however able) 0. UNDERSTANDS
COMA	ATOSE MORY	Autopsy request COGNITIVE PAT (Persistent vegetative solution of what was lead a. Short-term memory	e. TERI state/no 1.Yes rned or OK—se	discernible consciousness) (If yes, skip to Section G) known) eems/appears to recall after 5 minutes		CLARITY 6. ABILITYTO	3. RARELY/NEVER UNDERSTOOD (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words 0 (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of
COMA	ATOSE	Autopsy request COGNITIVE PAT (Persistent vegetative solution of the control of	e. TERI state/no 1. Yes rned or OK—se 1. Me OK—se	discernible consciousness) (If yes, skip to Section G) known) eems/appears to recall after 5 minutes mory problem eems/appears to recall long past		6. ABILITYTO UNDER-STAND	3. RARELY/NEVER UNDERSTOOD (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words 0. (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
COMA	ATOSE	Autopsy request COGNITIVE PAT (Persistent vegetative solution of what was lead a. Short-term memory of Memory OK	e. TERI state/no 1. Yes rned or OK—se 1. Me OK—se	discernible consciousness) (If yes, skip to Section G) known) eems/appears to recall after 5 minutes mory problem		6. ABILITYTO UNDER-STAND	3. RARELY/NEVER UNDERSTOOD (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words 0. (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS

SECTION D. VISION PATTERNS

_			
1.	VISION	(Ability to see in adequate light and with glasses if used)	
		O. ADEQUATE—sees fine detail, including regular print in newspapers/books I. IMPAIRED—sees large print, but not regular print in newspapers/books Dooks Doo	
2.	LIMITATIONS/	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	а. b. с.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

		flashes of light; sees "curtains" over e	eyes	b.
		NONE OF ABOVE		c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying of the second s	glass	
	AIT LIAITOLO	1.103		
SE	CTION E. M	OOD AND BEHAVIOR PATT	_	
1.	INDICATORS	(Code for indicators observed in la assumed cause)	ast 30 days, irrespective of the	
	OF DEPRES-	Indicator not exhibited in last 30 da Indicator of this type exhibited up to		
	SION, ANXIETY,	Indicator of this type exhibited dail Indicator of this type exhibited dail)
	SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS	h. Repetitive health complaints—e.g.,	
		a. Resident made negative	persistently seeks medical attention, obsessive concern	
		statements—e.g., "Nothing matters; Would rather be	with body functions	
		dead; What's the use; Regrets having lived so	 i. Repetitive anxious complaints/concerns (non- 	
		long; Let me die"	health related) e.g.,	
		b. Repetitive questions—e.g.,	persistently seeks attention/ reassurance regarding	
		"Where do I go; What do I do?"	schedules, meals, laundry, clothing, relationship issues	
		c. Repetitive verbalizations—	SLEEP-CYCLE ISSUES	
		e.g., calling out for help, ("God help me")	j. Unpleasant mood in morning	
		d. Persistent anger with self or others—e.g., easily	k. Insomnia/change in usual sleep pattern	
		annoyed, anger at placement in nursing home; anger at care received	SAD, APATHETIC, ANXIOUS APPEARANCE	
		e. Self deprecation—e.g., "/	 Sad, pained, worried facial expressions—e.g., furrowed 	
		am nothing; I am of no use to anyone"	brows	
		f. Expressions of what	m. Crying, tearfulness	
		appear to be unrealistic fears—e.g., fear of being	 n. Repetitive physical movements—e.g., pacing, 	
		abandoned, left alone,	hand wringing, restlessness, fidgeting, picking	
		being with others	LOSS OF INTEREST	
		g. Recurrent statements that something terrible is about	o. Withdrawal from activities of	
		to happen—e.g., believes he or she is about to die,	interest—e.g., no interest in long standing activities or	
		have a heart attack	being with family/friends	
2.	MOOD	One or more indicators of depresse	p. Reduced social interaction	
	PERSIS- TENCE	not easily altered by attempts to "o		
	TENCE	the resident over last 7 days 0. No mood 1. Indicators present		
3.	CHANGE	indicators easily altered Resident's mood status has changed	not easily altered	
٥.	IN MOOD	days ago (or since last assessment i	f less than 90 days)	
4	REHAVIORAI	0. No change 1. Improved (A) Behavioral symptom frequenc	2. Deteriorated	
٦.	SYMPTOMS	Behavior not exhibited in last 7 of the second	days	
		Behavior of this type occurred 1 Behavior of this type occurred 4 Behavior of this type occurred d	to 6 days, but less than daily	
		(B) Behavioral symptom alterability 0. Behavior not present OR behav 1. Behavior was not easily altered		(B)
		WANDERING (moved with no rational oblivious to needs or safety)		
		b. VERBALLY ABUSIVE BEHAVIOR were threatened, screamed at, cur		
		c. PHYSICALLY ABUSIVE BEHAVIOR were hit, shoved, scratched, sexual		
		d. SOCIALLY INAPPROPRIATE/DIS SYMPTOMS (made disruptive so self-abusive acts, sexual behavior smeared/threw food/feces, hoardir belongings)	unds, noisiness, screaming, or disrobing in public,	
		e. RESISTS CARE (resisted taking rassistance, or eating)	medications/ injections, ADL	

5.	CHANGE IN	Resident's behavi	or status has changed as	compared to status of 90	
			e last assessment if less	than 90 days)	
	SYMPTOMS	0. No change	 Improved 	Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF	At ease interacting with others	a.
	INITIATIVE/ INVOLVE-	At ease doing planned or structured activities	b.
	MENT	At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED	Covert/open conflict with or repeated criticism of staff	a.
	RELATION- SHIPS	Unhappy with roommate	b.
	эпігэ	Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	с.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

0. INDEPENDENT—No help or oversight—OR— Help/oversight provided only 1 or 2 times

1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)

	during last	7 days		
	last7 days	SION—Oversight, encouragement or cueing provided 3 or more times —OR— Supervision (3 or more times) plus physical assistance provi s during last 7 days	s durii ded c	ng only
	2. LIMITED A guided ma OR—More	ASSISTANCE—Resident highly involved in activity; received physical ineuvering of limbs or other nonweight bearing assistance 3 or more tile help provided only 1 or 2 times during last 7 days	help i mes -	in —
	period, hel —Weight-	VE ASSISTANCE—While resident performed part of activity, over last p of following type(s) provided 3 or more times: bearing support ff performance during part (but not all) of last 7 days	.7-da	у
		EPENDENCE—Full staff performance of activity during entire 7 days		
		DID NOT OCCUR during entire 7 days		
	`´OVER ALI	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED L SHIFTS during last 7 days; code regardless of resident's self-	(A)	(B)
	O. No setup o Setup help One persor	ce classification) r physical help from staff only n physical assist 8. ADL activity itself did not ons physical assist occur during entire 7 days	SELF-PERF	SUPPORT
a.	BED Mobility	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
C.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing , including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

	BATHING	Code for most dependent in	EXCLUDE washing of back and hair.) self-performance and support.	() (B)
		• •	NIMINOL codes appear below	A) (B)
		 Independent—No help pro Supervision—Oversight h 		
		Physical help limited to tra	, ,	
		 Physical help in part of bat 	thing activity	
		Total dependence		
		8. Activity itself did not occur	during entire 7 days defined in Item 1, code B above)	
3.	TEST FOR	(Code for ability during test in t		
	BALANCE	0. Maintained position as requ	ired in test	
	(see training	 Unsteady, but able to rebala Partial physical support duri 	nce self without physical support ng test;	n ir
	manual)	or stands (sits) but does not 3. Not able to attempt test with		
		a. Balance while standing	очер. 1, отом. 1. отр	
		b. Balance while sitting—positi	on, trunk control	
4.	FUNCTIONAL LIMITATION	(Code for limitations during las placed resident at risk of injury	t 7 days that interfered with daily function	ns or
	IN RANGE OF	(A) RANGE OF MOTION	(B) VOLUNTARY MOVEMENT	r
	MOTION	No limitation Limitation on one side	No loss Partial loss	
	(see training manual)	Limitation on both sides	2. Full loss (A	A) (B)
	manaan	a. Neckb. Arm—Including shoulder or	elbow	+
		c. Hand—Including wrist or fine	<u> </u>	+
		d. Leg—Including hip or knee	-	
		e. Foot—Including ankle or toe	s	
_		f. Other limitation or loss	act 7 days	
5.	MODES OF LOCOMO-	(Check all that apply during la Cane/walker/crutch		
	TION	Wheeled self	a. Wheelchair primary mode of locomotion	d.
		Other person wheeled	c. NONE OF ABOVE	е.
6.	MODES OF	(Check all that apply during la	ast 7 days)	
	TRANSFER	Bedfast all or most of time	Lifted mechanically	d.
		Bed rails used for bed mobility or transfer	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	
		Lifted manually	NONE OF ABOVE	e.
7.	TASK		ere broken into subtasks during last 7	f.
	SEGMENTA- TION	days so that resident could pe 0. No 1. Yes		
	11014			
8.	ADL	Resident believes he/she is ca	pable of increased independence in at	
8.	ADL FUNCTIONAL REHABILITA-	Resident believes he/she is ca least some ADLs	pable of increased independence in at	a.
8.	ADL FUNCTIONAL	Resident believes he/she is ca least some ADLs		a. b.
8.	ADL FUNCTIONAL REHABILITA- TION	Resident believes he/she is ca least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks	pable of increased independence in at nt is capable of increased independence /activity but is very slow	
8.	ADL FUNCTIONAL REHABILITA- TION	Resident believes he/she is ca least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform	pable of increased independence in at nt is capable of increased independence	b.
8.	ADL FUNCTIONAL REHABILITA- TION	Resident believes he/she is ca least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks	pable of increased independence in at nt is capable of increased independence /activity but is very slow	b. c. d.
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9. SE(ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C CONTINENCE (Code for resi	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performat to status of 90 days ago (or sidays) 0. No change 1. Imp DNTINENCE IN LAST 1 SELF-CONTROL CATEGOR dent's PERFORMANCE OVE	pable of increased independence in at nt is capable of increased independence in at it is capable of increased independence in activity but is very slow nance or ADL Support, comparing increased increased as compared not last assessment if less than 90 proved 2. Deteriorated it is a DAYS ADAYS IES RALL SHIFTS)	b. c. d. e.
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9. SE(ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. Co CONTINENCE (Code for resi device that of BOWEL, les 2. OCCASION BOWEL, on	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sidays) 0. No change 1. Imp DNTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE 17—Complete control [includes foces not leak urine or stool] CONTINENT—BLADDER, incost than weekly IALLY INCONTINENT—BLADIce a week	pable of increased independence in at not is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence or ADL Support, comparing increased inc	b. c. d. e.
9. SE(ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C CONTINENC (Code for resi device that of BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN control pres	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE ONTINENT—BLADDER, income stand weekly INCONTINENT—BLADDER, income stand weekly IALLY INCONTINENT—BLADDER and teg., on day shift); BOWEL,	pable of increased independence in at not is capable of increased independence was capable of increased independence was capable of increased independence was capable of increased independence as comparing once status has changed as compared note last assessment if less than 90 or over 2. Deteriorated 4 DAYS IES R ALL SHIFTS) use of indwelling urinary catheter or ostontinent episodes once a week or less; DER, 2 or more times a week but not daily. ER, tended to be incontinent daily, but son 2-3 times a week	b. c. d. e.
9. SE(ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C. CONTINENCE (Code for residue) 1. USUALLY C BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN control presidue) 4. INCONTINIA	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE ONTINENT—BLADDER, income stand weekly INCONTINENT—BLADDER, income stand weekly IALLY INCONTINENT—BLADDER and teg., on day shift); BOWEL,	pable of increased independence in at not is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence or ADL Support, comparing increased inc	b. c. d. e.
9. SE(ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C. CONTINENCE (Code for residue) 1. USUALLY C BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN control presidue) 4. INCONTINIA	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE TO-Complete control [includes to status of 10 days in the control of the time Control of bowel movement, we control the control of the c	pable of increased independence in at not is capable of increased independence was capable of increased independence was capable of increased independence was capable of increased independence as comparing once status has changed as compared note last assessment if less than 90 or over 2. Deteriorated 4 DAYS IES R ALL SHIFTS) use of indwelling urinary catheter or ostontinent episodes once a week or less; DER, 2 or more times a week but not daily. ER, tended to be incontinent daily, but son 2-3 times a week	b. c. d. e.
9. SE(ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. Co CONTINENC (Code for resi device that of BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN control pres 4. INCONTINE BOWEL, all BOWEL, all BOWEL CONTI- NENCE	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sindays) 0. No change 1. Imp DNTINENCE IN LAST 1 ESELF-CONTROL CATEGOR dent's PERFORMANCE OVE 17—Complete control [includes does not leak urine or stool] CONTINENT—BLADDER, inco is than weekly IALLY INCONTINENT—BLADDE Ce a week ITLY INCONTINENT—BLADDE Cent (e.g., on day shift); BOWEL, ENT—Had inadequate control E (or almost all) of the time Control of bowel movement, we programs, if employed	pable of increased independence in at not is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence at a comparing increase at the increa	b. c. d. e.
9. SE6 1.	ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C. CONTINENCE (Code for resi 0. CONTINENCE BOWEL, les 2. OCCASION BOWEL, on 3. FREQUENT control pres 4. INCONTINI BOWEL, all BOWEL CONTI- B	Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE ONTINENT—BLADDER, incost than weekly IT—Complete control [includes to the status of t	pable of increased independence in at not is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence in at it is capable of increased independence or ADL Support, comparing increased inc	b. c. d. e.
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9. SE€ 1.	ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. C. CONTINENCE (Code for resi 0. CONTINENCE BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN control pres 4. INCONTINE BOWEL, all BOWEL CONTINENCE BLADDER CONTI- NENCE BUADDER CONTI- NENCE BOWEL ELIMINATION	Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performar to status of 90 days ago (or sidays) 0. No change 1. Imp DNTINENCE IN LAST 1 SELF-CONTROL CATEGOR dent's PERFORMANCE OVE T—Complete control [includes does not leak urine or stool] CONTINENT—BLADDER, incost than weekly ALLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL, ENT—Had inadequate control E (or almost all) of the time Control of bowel movement, we programs, if employed Control of urinary bladder functions and elimination pattern regular—at least one	pable of increased independence in at not is capable of increased independence in at not is capable of increased independence in at its capable of increased independence in at its capable of increased independence in a compared increased increase	b. c. d. e.
9. SE6 1.	ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. CO CONTINENCE (Code for resi device that of BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN control pres 4. INCONTINE BOWEL, all BOWEL CONTI- NENCE BLADDER CONTI- NENCE BOWEL	Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performant to status of 90 days ago (or sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 ESELF-CONTROL CATEGOR dent's PERFORMANCE OVE IT—Complete control [includes to the status of leak urine or stool] FONTINENT—BLADDER, incomposition to the status of the status	pable of increased independence in at not is capable of increased independence was capable of increased independence was capable of increased independence was capable of increased independence or ADL Support, comparing the compared increased as compared increased as compared increased as compared increased. 4 DAYS IES R ALL SHIFTS) use of indwelling urinary catheter or ostore indivedling urinary catheter or ostore increased. DER, 2 or more times a week but not daily. ER, tended to be incontinent daily, but son 2-3 times a week. BLADDER, multiple daily episodes; with appliance or bowel continence. In the continence insufficient to the appliances (e.g., foley) or continence.	b. c. d. e.

4. SECCENCIONO Checomocococomocococomococococomoc	CHANGE IN URINARY CONTI-NENCE	Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter Resident's urinary continence	a. b. c.	Did not use toilet room/ commode/urinal Pads/briefs used Enemas/irrigation	f. g.
4. Checinoctinacti	CHANGE IN URINARY CONTI- NENCE	External (condom) catheter Indwelling catheter Intermittent catheter	c.		g.
SEC Chec nood	URINARY CONTI- NENCE	Indwelling catheter Intermittent catheter		Enomas/irrigation	
SEC Chec nood	URINARY CONTI- NENCE	Intermittent catheter		Literias/iirigau0f1	h.
SEC Chec nood	URINARY CONTI- NENCE			Ostomy present	i.
SEC Chec nood	URINARY CONTI- NENCE		e.	NONE OF ABOVE	j.
SEC Chec nood	URINARY CONTI- NENCE			l anged as compared to status of	
nood	NENCE	90 days ago (or since last ass	sessmer	nt if less than 90 days)	
nood		0. No change 1. lm	proved	2. Deteriorated	
nood					l
nood		SEASE DIAGNOSES			
	d and behavior			current ADL status, cognitive state onitoring, or risk of death. (Do not	
	ive diagnoses) DISEASES	(If none apply, CHECK the N	IONE O	F ABOVE box	
	DIOLAGES	,		Hemiplegia/Hemiparesis	.,
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Multiple sclerosis	v. w.
		Diabetes mellitus	_	Paraplegia	w. x.
		Hyperthyroidism	a. b.	Parkinson's disease	х. у.
		Hypothyroidism	c.	Quadriplegia	y. Z.
		HEART/CIRCULATION	c.	Seizure disorder	aa.
		Arteriosclerotic heart disease		Transient ischemic attack (TIA)	bb.
		(ASHD)	d.	Traumatic brain injury	CC.
		Cardiac dysrhythmias	е.	PSYCHIATRIC/MOOD	CC.
		Congestive heart failure	f.	Anxiety disorder	
		Deep vein thrombosis	g.	Depression	dd.
		Hypertension	h.	Manic depression (bipolar	ee.
		Hypotension	i.	disease)	ff.
		Peripheral vascular disease	j.	Schizophrenia	gg.
		Other cardiovascular disease	k.	PULMONARY	
		MUSCULOSKELETAL		Asthma	hh.
		Arthritis	I.	Emphysema/COPD	ii.
		Hip fracture	m.	SENSORY	
		Missing limb (e.g., amputation)	n.	Cataracts	jj.
		Osteoporosis	о.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	II.
		NEUROLOGICAL		Macular degeneration	mm
		Alzheimer's disease	q.	OTHER	
		Aphasia	r.	Allergies	nn.
		Cerebral palsy	s.	Anemia	00.
		Cerebrovascular accident (stroke)		Cancer	pp.
		` ,	t.	Renal failure	qq.
		Dementia other than Alzheimer's disease	u.	NONE OF ABOVE	rr.
2. I		(If none apply, CHECK the N		FABOVE box)	
		Antibiotic resistant infection		Septicemia	g.
		(e.g., Methicillin resistant staph)	a.	Sexually transmitted diseases	h.
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
		, ,		Urinary tract infection in last 30	ļ
		Conjunctivitis HIV infection	C.	days	j.
			d.	Viral hepatitis	k.
		Pneumonia	e.	Wound infection	I.
_		Respiratory infection	f.	NONE OF ABOVE	m.
3.	OTHER CURRENT	a			
	OR MORE	b.			I
	DETAILED DIAGNOSES	c.			

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS		(Check all problems present in last 7 days unless other time frame is indicated)				
		INDICATORS OF FLUID		Dizziness/Vertigo	f.		
		STATUS		Edema	g.		
		Weight gain or loss of 3 or		Fever	h.		
		more pounds within a 7 day	_	Hallucinations	i.		
		period	a.	Internal bleeding			
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in last 90 days	k.		
		Dehydrated; output exceeds		Shortness of breath	i.		
		input	C.	Syncope (fainting)	m.		
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.		
		provided during last 3 days	d.	Vomiting	0.		
		OTHER		NONE OF ABOVE	p.		
		Delusions	e.				

2.	PAIN	(Code the highest level of pa	in prese	ent in the last 7 days)			
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain			
		resident complains or shows evidence of pain		1. Mild pain			
		0. No pain (<i>skip to J4</i>)		2. Moderate pain			
		1. Pain less than daily		Times when pain is horrible or excruciating			
		2. Pain daily		3			
3.	PAIN SITE	(If pain present, check all site	s that ap	oply in last 7 days)			
		Back pain	a.	Incisional pain	f.		
		Bone pain	b.	Joint pain (other than hip)	g.		
		Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.		
		Headache	d.	Stomach pain			
			u.	'	i.		
		Hip pain	e.	Other	j.		
4.	ACCIDENTS	(Check all that apply)					
		Fell in past 30 days	a.	Hip fracture in last 180 days	C.		
		Fell in past 31-180 days	b.	Other fracture in last 180 days	d.		
				NONE OF ABOVE	e.		
5.	STABILITY OF	Conditions/diseases make respatterns unstable—(fluctuating		cognitive, ADL, mood or behavior rious, or deteriorating)	a.		
	CONDITIONS						
		End-stage disease, 6 or fewer	months	to live	c.		
		NONE OF ABOVE			d.		

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL	Chewing problem			a.		
	PROBLEMS	Swallowing problem			b.		
		Mouth pain			c.		
		NONE OF ABOVE					
2.	HEIGHT AND WEIGHT	recent measure in last 30 day	Record (a.) height in inches and (b.) weight in pounds. Base weight on recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes				
3.	WEIGHT CHANGE	180 days 0. No 1. Yes b. Weight gain—5 % or more					
		180 days 0. No 1. Yes	.				
4.	NUTRI- TIONAL	Complains about the taste of many foods	a.	Leaves 25% or more of food uneaten at most meals	c.		
	PROBLEMS	Regular or repetitive complaints of hunger	b.	NONE OF ABOVE	d.		
5.	NUTRI-	(Check all that apply in last	t 7 days	5)			
	TIONAL APPROACH-	Parenteral/IV	a.	Dietary supplement between meals	f.		
	ES	Feeding tube	b.		۱.		
		Mechanically altered diet	c.	Plate guard, stabilized built-up utensil, etc.	g.		
		Syringe (oral feeding) Therapeutic diet	d.	On a planned weight change program			
		Therapeutic diet	e.	NONE OF ABOVE	h. i.		
6.	PARENTERAL	(Skip to Section L if neither 5	a nor 5	b is checked)			
	OR ENTERAL INTAKE	a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%					
		b. Code the average fluid inta 0. None 1. 1 to 500 cc/day	. 3	day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 1. 1501 to 2000 cc/day			

SECTION L. ORAL/DENTAL STATUS

1.		Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	DISEASE PREVENTION	Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	a.

SEC	CTION M. S	KIN CONDITION	
1.	ULCERS (Due to any	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	cause)	Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	<u> </u>
		 Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. 	
		Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	
4.	OTHER SKIN	(Check all that apply during last 7 days)	
4.	PROBLEMS	Abrasions, bruises	a.
	OR LESIONS	Burns (second or third degree)	b.
	PRESENT	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	C.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	е.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN	(Check all that apply during last 7 days)	11.
-	TREAT-	Pressure relieving device(s) for chair	a.
	MENTS	Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	g.
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet)	i.
		NONE OF ABOVE	j.
6.	FOOT	(Check all that apply during last 7 days)	
	PROBLEMS AND CARE	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	c.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		inserts, pads, toe separators)	
		Application of dressings (with or without topical medications)	f.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour				
		per time period) in the: Morning	a.	Evening	c.	
		Afternoon	b.	NONE OF ABOVE	d.	
(If r	esident is co	matose, skip to Se	ction C	D)		
2.	AVERAGE TIME	(When awake and not	receivi	ng treatments or ADL care)		
	INVOLVED IN	0. Most—more than 2/3 1. Some—from 1/3 to 2				
3.		(Check all settings in	which a	ctivities are preferred)		
	ACTIVITY SETTINGS	Own room Day/activity room	a. b.	Outside facility	d.	
		Inside NH/off unit	C.	NONE OF ABOVE	е.	
4.	GENERAL		VCES w	hether or not activity is currently		
	ACTIVITY PREFER-	available to resident) Cards/other games	a.	Trips/shopping	g.	
	ENCES	Crafts/arts	а. b.	Walking/wheeling outdoors	h.	
	(adapted to resident's	Exercise/sports	C.	WatchingTV	i.	
	current	Music	d.	Gardening or plants	j.	
	abilities)	Reading/writing	e.	Talking or conversing	k.	
		Spiritual/religious		Helping others	I.	
		activities	f.	NONE OF ABOVE	m.	

Numeric Identifier		

5.			erences in daily routines						
	CHANGE IN	0. No change	Slight change	Major change					
	DAILY ROUTINE	a. Type of activities in	Type of activities in which resident is currently involved						
	b. Extent of resident involvement in activities								

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICA- TIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)				
2.	NEW MEDICA- TIONS	Resident currently receiving medications that were initiated during the ast 90 days) No 1.Yes				
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)				
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic				

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL	a. SPECIAL CARE—Check to	eatmen	ts or programs receiv	ed du	ring		
	TREAT- MENTS.	the last 14 days		, 0		Ü		
	PROCE-	TREATMENTS		Ventilator or respira	tor			
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			I.	
		Dialysis	b.	Alcohol/drug treatm	ent			
		IV medication	c.	program			m.	
		Intake/output	d.	Alzheimer's/demen	tia spe	ecial		
		Monitoring acute medical		care unit			n.	
		condition	e.	Hospice care Pediatric unit			o. p.	
		Ostomy care	f.	Respite care			q.	
		Oxygen therapy	g.	Training in skills req	uired	to		
		Radiation	h.	return to the comm	unity (e.g.,		
		Suctioning	i.	taking medications, work, shopping, trar			r.	
		Tracheostomy care	j.	ADLs)	•			
		Transfusions	k.	NONE OF ABOVE			s.	
		b.THERAPIES - Record the following therapies was as						
		the last 7 calendar days	(Enter (0 if none or less that				"
		[Note—count only post a (A) = # of days administered			DAYS	м	iN	
		(B) = total # of minutes pro		minutes of more	(A)		В)	
		a. Speech - language patholo	gy and	audiology services			П	
		b. Occupational therapy						
		c. Physical therapy					+	
		d. Respiratory therapy					T	
		e. Psychological therapy (by a health professional)	any lice	nsed mental				
2.	INTERVEN-	(Check all interventions or s	trategie	es used in last 7 day	s—no)	_	
	TION	matter where received)						
	FOR MOOD,	Special behavior symptom eva			_		a.	
	BEHAVIOR, COGNITIVE	Evaluation by a licensed ment	al health	n specialist in last 90	days		b.	
	LOSS	Group therapy					c.	
		Resident-specific deliberate ch mood/behavior patterns—e.g.					d.	
		Reorientation—e.g., cueing					e.	
		NONE OF ABOVE					f.	
3.	NURSING	Record the NUMBER OF DA						
	REHABILITA- TION/	restorative techniques or pra more than or equal to 15 m					or	
	RESTOR-	(Enter 0 if none or less than		daily.)				
	ATIVE CARE	a. Range of motion (passive)		f. Walking				
		b. Range of motion (active)		g. Dressing or groor	ming			
		c. Splint or brace assistance		h. Eating or swallow	ing			
		TRAINING AND SKILL PRACTICE IN:		i. Amputation/prost	hesis	care		
		d. Bed mobility		j. Communication				
		e. Transfer		k. Other				

4.	DEVICES	(Use the following codes for last 7 days :)	
	AND	Not used Head less than daily.	
	RESTRAINTS	Used less than daily Used daily	
		Red rails	
		250.10.0	
		a. — Full bed rails on all open sides of bed	
		b. — Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
5.	HOSPITAL	Record number of times resident was admitted to hospital with an	
	STAY(S)	overnight stay in last 90 days (or since last assessment if less than 90	
		days). (Enter 0 if no hospital admissions)	
6.		Record number of times resident visited ER without an overnight stay	
	ROOM (ER) VISIT(S)	in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)	
	VISIT(3)		
7.		In the LAST 14 DAYS (or since admission if less than 14 days in	
	VISITS	facility) how many days has the physician (or authorized assistant or	
		practitioner) examined the resident? (Enter 0 if none)	
8.		In the LAST 14 DAYS (or since admission if less than 14 days in	
	ORDERS	facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? <i>Do not include order</i>	
		renewals without change. (Enter 0 if none)	
9	ABNORMAL	Has the resident had any abnormal lab values during the last 90 days	
٥.		(or since admission)?	
		<u></u>	
		0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community				
		0. No	1.Yes			
		b. Resident has a support person who is positive towards discharge				
		0. No	1. Yes			
		C. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) O. No 2. Within 31-90 days				
			days 3. Disch			
2.	OVERALL CHANGE IN	compared to s	erall self sufficiency tatus of 90 days a	has chang go (or since	ed significantly as a last assessment if less	
	CARE NEEDS	than 90 days)	4.1		0.5	
		U. No change	 Improved—reconsupports, need restrictive level 	s less	Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPA-	a. Resident:	0. No	1.Yes		
	TION IN ASSESS-	b. Family:	0. No	1.Yes	No family	
	MENT	c. Significant other:	0. No	1.Yes	2. None	
2.	SIGNATURE	S OF PERSONS	COMPLETING	THE AS	SESSMENT:	
a. S	ignature of RN	Assessment Coordi	nator (sign on ab	ove line)		
	ate RN Assess gned as comple	ment Coordinator ete			_	
		'	Month	Day	Year	_
				-		
c.O	ther Signatures	}	Title		Sections	Date
d.						Date
						- D -
e.						Date
f.						Date
g.						Date
h.						Date

₹e:		

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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	TREAT-		on therapy	y adm	iniste	ered (for at leas		ninu	tes a	day) in the
	MENTS AND PROCE-	last 7 da	ays (Ente	r 0 if ı	none))				AYS		MIN
	DURES	(A) = # of d (B) = total							+	(A)		(B)
		Skip unles return ass			dica	re 5 d	ay or Med	licare	reac	lmis	sion	1
			therapie	s to b onal tl	egin	in FİF	hysician o RST 14 da speech pa	s of s	stay-	-phy		
		If not orde	ered, skip	to ite	em 2							
		c. Through when at delivered	least 1 th				nate of the an be exp					
				acros	s the		nate of the apies) that					
2.	WALKING WHEN MOST SELF SUFFICIENT	Physical training Reside Physical	ent receive al therapy g (T.1.b) ent receive	ed phy was d ed nur	sical order	least theraped for ehabi		follov gait tr nt invol valking	ving rainin Iving g (P.3	are g (P. [,] gait .f)	1.b.c)	
		Skip to ite	m 3 if res	ident	did n	ot wa	alk in last 7	days	;			
		(FOR FOL EPISODE WITHOUT REHABILI	WHEN TH SITTING	IE RE	SIDE N. IN	EŃT V ICLUI	VALKEDT	HE FA	RTH	EST		
		a. Furthe		nce w	alked	d with	out sitting d	own d	luring	this		
)+ feet 149 feet 50 feet				3. 10-25 fe 4. Less th		feet			
		b. Time	walked w	rithout	sittin	g dow	n during th	is epis	sode.			
		1. 3-4	minutes minutes 0 minutes				3. 11-15 n 4. 16-30 n 5. 31+ mir	ninute				
		c. Self-P	erformar	nce in	walk	k ing d	uring this e	pisode	Э.			
		1. <i>SUI</i>	PERVISIO				oversight encourager	nent o	rcue	ing		
		2. LIM rece		sical h	elp in	guide	sident high ed maneuv					
		3. <i>EX</i>	•	ASSI	STAN	ICE-	-Resident r	eceive	ed we	eight		
		d. Walkii regard	ng suppo dless of re	ort pro sident	ovide 's sel	d ass f-perfo	ociated wit ormance cl	n this e assific	episo ation	de (c).	ode	
		1. Seti	setup or p up help or e person p	nlý			n staff					
		3. Two	+ person	s phys	sical a	ssist	n associatio	n with	thic	anica	nde	
		0. No	Ci Dai 3 U	1.Yes		acı II II	i associalic	nı vvilli	i u 115 (opiac	лос.	
3.	CASE MIX GROUP	Medicare					State					
				1		ш			-	-		ш

Numeric Identifier SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Resident's Name: Medical Record No.: 1. Check if RAP is triggered. 2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status. · Describe: — Nature of the condition (may include presence or lack of objective data and subjective complaints). — Complications and risk factors that affect your decision to proceed to care planning. — Factors that must be considered in developing individualized care plan interventions. — Need for referrals/further evaluation by appropriate health professionals. Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.). 3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found. 4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs). (b) Care Planning Decision—check (a) Check if Location and Date of if addressed in A. RAP PROBLEM AREA triggered **RAP Assessment Documentation** care plan 1. DELIRIUM 2. COGNITIVE LOSS 3. VISUAL FUNCTION 4. COMMUNICATION 5. ADL FUNCTIONAL **REHABILITATION POTENTIAL** 6. URINARY INCONTINENCE AND **INDWELLING CATHETER** 7. PSYCHOSOCIAL WELL-BEING 8. MOOD STATE 9. BEHAVIORAL SYMPTOMS 10. ACTIVITIES 11. FALLS 12. NUTRITIONAL STATUS 13. FEEDING TUBES 14. DEHYDRATION/FLUID MAINTENANCE 15. DENTAL CARE 16. PRESSURE ULCERS 17. PSYCHOTROPIC DRUG USE 18. PHYSICAL RESTRAINTS

1. Signature of RN Coordinator for RAP Assessment Process

Year

2.

Month

Day

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0) T (Minay moninonos and monthly Calledor) = One item required to trigger 2= Two items required to trigger | 40,400 militarion 17,300-4 @ | 40/1/8411891818 | 40/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8 Osmoraion Puio Maintenance ★ = One of these three items, plus at least one other item required to trigger @=When both ADL triggers present, maintenance takes Coming Lossonmia Psychologic Drug Uso precedence Benedical Smalons Physical Resigning Acivilies Tigger A | Numicoal States - Pressure Urers 1 Adimies Tigger F | Communication Footing Tibes Proceed to RAP Review once triggered MDS ITEM CODE B2a Short term memory Long term memor Decision making Indicators of delirium JeA Behavioral symptoms Charge in behavioral symptoms Change in behavioral symptoms Establishes over gods/ Unsettled relationships Strong pt. rass / okes Lost roles ADL self-performance G16A G Balance Bedfast Glaucoma 1111 Denydration diagnosis

Lung aspirations

ET Lines, Incomingon and Inchesing Callesia. RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0) = One item required to trigger 2= Two items required to trigger 1 40, 1/4 minorano nigor 8 @ A Dervotation Fluio Wainenance ★ = One of these three items, plus at least one other item required to trigger @=When both ADL triggers present, maintenance takes A Coming Lossonmia A Psychologic Drug Uso precedence A Before Smoons L Acivilies Tilger A 3 Trigger B " Pestraints 1 Numinal Saus A Pessule Users J Communication A Fooding Titles Proceed to RAP Review once triggered Aoiviies 7 MDS ITEM CODE Swallowing problem Previous pressure ulc Awake morning Involved in activities Antipsychotics Antidepréssants

MDS QUARTERLY ASSESSMENT FORM

IVIL	JO QUAR	ERLY ASSESSIVIENT FORIVI
A1.	RESIDENT NAME	
40	DOOM	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
A2.	ROOM NUMBER	
А3.	ASSESS- MENT	a. Last day of MDS observation period
	REFERENCE DATE	Month Day Year
		Month Day Year b. Original (0) or corrected copy of form (enter number of correction)
A4a	DATE OF	Date of reentry from most recent temporary discharge to a hospital in
	REENTRY	last 90 days (or since last assessment or admission if less than 90 days)
A6.	MEDICAL	Month Day Year
Αυ.	MEDICAL RECORD NO.	
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1.Yes (Skip to Section G)
B2.	MEMORY	(Recall of what was learned or known)
		Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem
		b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
B4.	COGNITIVE SKILLS FOR	(Made decisions regarding tasks of daily life)
	DAILY DECISION- MAKING	INDEPENDENT—decisions consistent/reasonable MODIFIED INDEPENDENCE—some difficulty in new situations only
	MARINO	MÓDERATELY IMPAIRED—decisions poor; cues/supervision required
R5	INDICATORS	3. SEVERELY IMPAIRED—never/rarely made decisions (Code for behavior in the last 7 days.) [Note: Accurate assessment
	OF DELIRIUM—	requires conversations with staff and family who have direct knowledge of resident's behavior over this time].
	PERIODIC	Behavior not present
	DISOR- DERED	Behavior present, not of recent onset
	THINKING/ AWARENESS	Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)
	,	a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF
		SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
		C. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
		d.PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
		PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
		MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
C4.	MAKING	(Expressing information content—however able)
	SELF UNDER-	UNDERSTOOD USUALLY UNDERSTOOD—difficulty finding words or finishing
	STOOD	thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete
		requests 3. RARELY/NEVER UNDERSTOOD
C6.	ABILITYTO	(Understanding verbal information content—however able)
	UNDER- STAND	UNDERSTANDS UNDERSTANDS—may miss some part/intent of
	OTHERS	message
		2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
E1.	INDICATORS	3. RARELY/NEVER UNDERSTANDS (Code for indicators observed in last 30 days, irrespective of the
	OF DEPRES-	assumed cause) 0. Indicator not exhibited in last 30 days
	SION,	Indicator of this type exhibited up to five days a week Indicator of this type exhibited daily or almost daily (6, 7 days a week)
	ANXIETY, SAD MOOD	VERBAL EXPRESSIONS c. Repetitive verbalizations—
		oF DISTRESS e.g., calling out for help, ("God help me")
		statements—e.g., "Nothing d. Persistent anger with self or
		matters; Would rather be others—e.g., easily annoyed, anger at placement in
		Regrets having lived so nursing home; anger at care long; Let me die" received
		b. Repetitive questions—e.g., "I am nothing; I am of no use to anyone"

E1.	INDICATORS OF	VERBAL EXPRESSIONS OF DISTRESS SLEEP-CYCLE ISSUES j. Unpleasant mood in morning	
	DEPRES- SION.	f. Expressions of what k. Insomnia/change in usual	
	ANXIETY, SAD MOOD	appear to be unrealistic sleep pattern sleep pattern	
	(cont.)	abandoned, left alone, being with others SAD, APATHETIC, ANXIOUS APPEARANCE	
		g. Recurrent statements that	
		something terrible is about to happen—e.g., believes expressions—e.g., furrowed brows	
		he or she is about to die, have a heart attack m. Crying, tearfulness	
		h. Repetitive health n. Repetitive physical movements—e.g., pacing,	
		complaints—e.g., persistently seeks medical hand wringing, restlessness, fidgeting, picking	
		concern with body LOSS OF INTEREST	
		functions o. Withdrawal from activities of interest—e.g., no interest in	
		complaints/concerns (non-	
		persistently seeks attention/	
		reassurance regarding schedules, meals, laundry,	
E2.	MOOD	clothing, relationship issues One or more indicators of depressed, sad or anxious mood were	
	PERSIS- TENCE	not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days	
	12.102	No mood 1. Indicators present, 2. Indicators present, indicators easily altered not easily altered	
E4.	BEHAVIORAL	(A) Behavioral symptom frequency in last 7 days	
	SYMPTOMS	D. Behavior not exhibited in last 7 days Behavior of this type occurred 1 to 3 days in last 7 days	
		Behavior of this type occurred 4 to 6 days, but less than daily Behavior of this type occurred daily	
		(B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered	
		Behavior was not easily altered	(B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming,	
		self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others'	
		belongings)	
C1	(A) ADI SELE	e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	<u>,</u>
G1.		r-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALI uring last 7 days —Not including setup)	_
	INDEPEN during last	DENT—No help or oversight —OR— Help/oversight provided only 1 or 2 7 days	2 times
	last7 days	SION—Oversight, encouragement or cueing provided 3 or more times demo- OR—Supervision (3 or more times) plus physical assistance providers during last 7 days	uring d only
		Sudming last 7 days ASSISTANCE—Resident highly involved in activity; received physical hel	p in
		neuvering of limbs or other nonweight bearing assistance 3 or more time e help provided only 1 or 2 times during last 7 days	ės—
		VE ASSISTANCE—While resident performed part of activity, over last 7-	day
		p of following type(s) provided 3 or more times: bearing support f performance during part (but not all) of last 7 days	
		FPENDENCE—Full staff performance of activity during entire 7 days	
	8. ACTIVITY	DID NOT OCCUR during entire 7 days	(A)
a.	BED Mobility	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c.	WALK IN ROOM	How resident walks between locations in his/her room.	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit.	
e.	LOCOMO- TION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	LOCOMO-	How resident moves to and returns from off unit locations (e.g., areas	
	TION OFF UNIT	set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing , including donning/removing prosthesis	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of	
		nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

Numaria	Idontifior

i.	TOILET USE	How resident uses the toilet ro	om (or c	commode, bedoa	an. urinal):		
		transfer on/off toilet, cleanses, catheter, adjusts clothes	transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes				
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)					
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below					
		Independent—No help pro		_ codes appea.	20.011	_ (4	A)
		Supervision—Oversight h		,			
		2. Physical help limited to tra	ınsfer or	nly			
		3. Physical help in part of ba	thing ac	tivity			
		4. Total dependence					
		8. Activity itself did not occur					
G4.	FUNCTIONAL LIMITATION	(Code for limitations during las		s that interfered	with daily func	tions c	or
	IN RANGE OF	(A) RANGE OF MOTION	<i>y</i> ,	(B) VOLUNTA	ARY MOVEME	NT	
	MOTION	No limitation Limitation on one side		Ò. No loss1. Partial los	S		
		Limitation on both sides		2. Full loss		(A)	(B)
		a. Neck	olbou				
		b. Arm—Including shoulder orc. Hand—Including wrist or fin				-	
		d. Leg—Including hip or knee	yers				
		e. Foot—Including ankle or too	es				
		f. Other limitation or loss					
G6.	MODES OF	(Check all that apply during I	ast 7 da	ays)			
	TRANSFER	Bedfast all or most of time	_	NONE OF AB	OVE		
		Bed rails used for bed mobility	a.	-		f.	
		or transfer	b.				
H1.		E SELF-CONTROL CATEGOR Ident's PERFORMANCE OVE		SHIFTS)			
	0. CONTINEN	IT—Complete control [includes	use of i	ndwelling urinar	y catheter or os	stomy	
		does not leak urine or stool] CONTINENT—BLADDER, inco	ntinent	enisodes once a	week or less:		
	BOWEL, les	ss than weekly					
	BOWEL, on	IALLY INCONTINENT—BLAD ce a week	DER, 2	or more times a	week but not d	ally;	
		TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL			nent daily, but s	ome	
	BOWEL, all	ENT—Had inadequate control E (or almost all) of the time	BLADDI	ER, multiple dail	y episodes;		
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	• • •				
b.	BLADDER CONTI- NENCE	Control of urinary bladder fund soak through underpants), wit programs, if employed				:	
H2.	BOWEL ELIMINATION PATTERN	Fecal impaction	d.	NONE OF AB	OVE	e.	
Н3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling cath	eter		
	AND PROGRAMS]	a.	1		d.	
	FROGRAMO	Bladder retraining program	b.	Ostomy preser		i.	
		External (condom) catheter	c.	NONE OF AB	OVE	j.	
12.	INFECTIONS	Urinary tract infection in last 30 days	L	NONE OF AB	OVE	m.	
13.	OTHER	(Include only those diseases				nave a	7
	CURRENT DIAGNOSES	relationship to current ADL s medical treatments, nursing m				or stat	tus,
	AND ICD-9	, 3		Г			
	CODES	a			1111	•	
		b.				•	Ш
J1.	PROBLEM	(Check all problems present	t in last				\Box
	CONDITIONS	Dehydrated; output exceeds input	c.	Hallucinations		<u>i.</u>	
		-		NONE OF ABo		p.	
J2.	PAIN SYMPTOMS	(Code the highest level of pa	uri prese		- /		
		a. FREQUENCY with which resident complains or		b. INTENSITY	or pain		
		shows evidence of pain		 Mild pain Moderate pa 	in		
		0. No pain (skip to J4)		3. Times when			
		Pain less than daily Pain daily		or excrutiatin			
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in	last 180 davs	c.	
		Fell in past 30 days	a.	Other fracture	-		\neg
		Fell in past 31-180 days	b.	NONE OF AB	01/5	e.	

	Numeric ident		
J5.	STABILITY	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)	l l
	CONDITIONS	Resident experiencing an acute episode or a flare-up of a recurrent or	a.
		chronic problem	b.
		End-stage disease, 6 or fewer months to live	C.
K3.	WEIGHT	NONE OF ABOVE a. Weight loss—5 % or more in last 30 days; or 10 % or more in last	d.
	CHANGE	180 days	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last	
		180 days	
<u></u>	MUTTO	0. No 1. Yes Feeding tube	
K5.	NUTRI- TIONAL	On a planned weight change program	b. h.
	APPROACH- ES	NONE OF ABOVE	i.
M1.	ULCERS	(Record the number of ulcers at each ulcer stage—regardless of	ber
	(Due to any	cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	cause)	a. Stage 1. A persistent area of skin redness (without a break in the	2 10
		skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous	
		tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost,	
B40	T/DE 05	exposing muscle or bone. (For each type of ulcer, code for the highest stage in the last 7 days	ueina
M2.	TYPE OF ULCER	scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		 a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue 	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower	
N1.	TIME	extremities (Check appropriate time periods over last 7 days)	
IN I.	AWAKE	Resident awake all or most of time (i.e., naps no more than one hour	
		per time period) in the: Morning Evening	c.
///		Afternoon b. NONE OF ABOVE	d.
(IT r N2.		matose, skip to Section O) (When awake and not receiving treatments or ADL care)	
142.	TIME	,	
	ACTIVITIES	1. Some—from 1/3 to 2/3 of time 3. None	
01.	NUMBER OF MEDICA-	(Record the number of different medications used in the last 7 days, enter "0" if none used)	
	TIONS	,	
O4.	DAYS RECEIVED	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	
	THE FOLLOWING	a. Antipsychotic d. Hypnotic	
	MEDICATION	I e. Diuretic	
P4.	DEVICES	c. Antidepressant Use the following codes for last 7 days:	
P4.	AND	0. Not used	
	RESTRAINTS	Used less than daily Used daily	
		Bed rails	
		 a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) 	
		c. Trunk restraint	
		d. Limb restraint	
	0.750	e. Chair prevents rising	
Q2.	OVERALL CHANGE IN	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less	
	CARE NEEDS	than 90 days) 0. No change	
		supports, needs less more support restrictive level of care	
R2.	SIGNATURE	S OF PERSONS COMPLETING THE ASSESSMENT:	
a. S	ignature of RN	Assessment Coordinator (sign on above line)	
	ate RN Assessi igned as comple	ment Coordinator	
	.gr.ou do comp.i	Month Day Year	
	W. O' .	T-1	
c.C	other Signatures	Title Sections	Date
d.			Date
e.			Date
f.			Date
g.			Date

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG III)

A1.	RESIDENT		
	NAME		_
A2.	POOM	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr	r)
AZ.	ROOM NUMBER		
А3.	ASSESS- MENT	a. Last day of MDS observation period	
	REFERENCE DATE		
	DAIE	Month Day Year	
		b. Original (0) or corrected copy of form (enter number of correction)	
A4.	DATE OF	Date of reentry from most recent temporary discharge to a hospital in	
	REENTRY	last 90 days (or since last assessment or admission if less than 90 day	ys
		Month Day Year	
A6.	MEDICAL RECORD NO.		
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G)	
B2.	MEMORY	(Recall of what was learned or known)	
		a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem	
		b. Long-term memory OK—seems/appears to recall long past	
		0. Memory OK 1. Memory problem	
В3.	MEMORY/ RECALL	(Check all that resident was normally able to recall during last 7 days)	
	ABILITY	Current season That he/she is in a nursing home	
		Location of own room Staff names/faces C. NONE OF ABOVE are recalled e.	
B4.	COGNITIVE	(Made decisions regarding tasks of daily life)	
	SKILLS FOR DAILY	0. INDEPENDENT—decisions consistent/reasonable	
	DECISION- MAKING	MODIFIED INDEPENDENCE—some difficulty in new situations only	
		MODERATELY IMPAIRED—decisions poor; cues/supervision required	
		3. SEVERELY IMPAIRED—never/rarely made decisions	
B5.	INDICATORS OF	requires conversations with staff and family who have direct knowledge	ge
	DELIRIUM— PERIODIC	of resident's behavior over this time].	
	DISOR- DERED	Behavior not present Behavior present, not of recent onset	
	THINKING/ AWARENESS	 Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) 	l
	AWARENESS	a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)	
		b.PERIODS OF ALTERED PERCEPTION OR AWARENESS OF	
		SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and	
		day)	
		c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	
		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin,	
		clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)	
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)	
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors	
C4.	MAKING	sometimes present, sometimes not) (Expressing information content—however able)	
C4.	SELF	0. UNDERSTOOD	
	UNDER- STOOD	USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts	
		SOMETIMES UNDERSTOOD—ability is limited to making concrete requests	
00	ADII ITYTO	3. RARELY/NEVER UNDERSTOOD	
C6.	ABILITYTO UNDER-	(Understanding verbal information content—however able) 0. UNDERSTANDS	
	STAND OTHERS	USUALLY UNDERSTANDS—may miss some part/intent of message	
		2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication	J
		3. RARELY/NEVER UNDERSTANDS	
E1.	INDICATORS OF	(Code for indicators observed in last 30 days, irrespective of the assumed cause)	
	DEPRES- SION,	Indicator not exhibited in last 30 days Indicator of this type exhibited up to five days a week	
	ANXIETY, SAD MOOD	2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
	J. 12 11100D	1	

	Numeric Ident	itier		
E1.	INDICATORS OF DEPRES-	VERBAL EXPRESSIONS OF DISTRESS	h. Repetitive health complaints—e.g.,	
	SION, ANXIETY, SAD MOOD	a. Resident made negative statements—e.g., "Nothing matters; Would rather be	persistently seeks medical attention, obsessive concern with body functions	
		dead; What's the use; Regrets having lived so long; Let me die"	i. Repetitive anxious complaints/concerns (non-health related) e.g.,	
		b. Repetitive questions—e.g., "Where do I go; What do I	persistently seeks attention/ reassurance regarding schedules, meals, laundry,	
		do?" c. Repetitive verbalizations— e.g., calling out for help,	clothing, relationship issues SLEEP-CYCLE ISSUES	
		("God help me")	j. Unpleasant mood in mornink. Insomnia/change in usual	g
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home;	sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE	
		anger at care received e. Self deprecation—e.g., "I am of no use	I. Sad, pained, worried facial expressions—e.g., furrowed brows	
		to anyone" f. Expressions of what	m. Crying, tearfulnessn. Repetitive physical	
		appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	movements—e.g., pacing, hand wringing, restlessness fidgeting, picking	,
		g. Recurrent statements that something terrible is about	LOSS OF INTERESTo. Withdrawal from activities of	
		to happen—e.g., believes he or she is about to die, have a heart attack	interest—e.g., no interest in long standing activities or being with family/friends	
F2	MOOD	One or more indicators of dep	p. Reduced social interaction ressed, sad or anxious mood were	
E2.	MOOD PERSIS- TENCE		to "cheer up", console, or reassure	
		No mood 1. Indicators president indicators easily altered	sent, 2. Indicators present, not easily altered	
E4.	BEHAVIORAL SYMPTOMS	O. Behavior not exhibited in la Behavior of this type occur	st 7 days red 1 to 3 days in last 7 days red 4 to 6 days, but less than daily	
		(B) Behavioral symptom altera 0. Behavior not present OR b 1. Behavior was not easily altr a. WANDERING (moved with no	ehavior was easily altered ered (A	(B)
		oblivious to needs or safety) b. VERBALLY ABUSIVE BEHA		+
		were threatened, screamed a c. PHYSICALLY ABUSIVE BEH were hit, shoved, scratched, s	HAVIORAL SYMPTOMS (others	+
		d. SOCIALLY INAPPROPRIATE SYMPTOMS (made disruptiv self-abusive acts, sexual beha	E/DISRUPTIVE BEHAVIORAL e sounds, noisiness, screaming,	
		assistance, or eating)	ring medications/ injections, ADL	
G1.	SHIFTS d	uring last 7 days—Not including	• •	
	during last	7 days	DR— Help/oversight provided only 1 on the control of the control o	
	last7 days 1 or 2 time	—OR— Supervision (3 or more s s during last 7 days	times) plus physical assistance provid	ed only
	guided ma		nvolved in activity; received physical h eight bearing assistance 3 or more tin during last 7 days	
	period, hel —Weight-	p of following type(s) provided 3 o bearing support		7-day
		f performance during part (but no FPENDENCE—Full staff performa	ance of activity during entire 7 days	
		DID NOT OCCUR during entire		
	OVER ALL	PORT PROVIDED—(<i>Code for M</i> . <i>SHIFTS during last 7 days; co</i> ce classification)	de regardless of resident's self-	(A) (B)
	O. No setup o Setup help	r physical help from staff only	8 ADI activity itaalif did not	SELF-PERF SUPPORT
	3. Two+ perso	n physical assist ons physical assist		SEL
a.	BED		n lying position, turns side to side,	
_	MOBILITY	and positions body while in bed How resident moves between su		

G1.			(A)	(B)
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing , including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below		(A)
		Independent—No help provided Supervision—Oversight help only		
		Physical help limited to transfer only Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days		
G3.	TEST FOR BALANCE	(Code for ability during test in the last 7 days)		
	(see training manual)	Maintained position as required in test Unsteady, but able to rebalance self without physical support Partial physical support during test; or stands (sits) but does not follow directions for test Not able to attempt test without physical help		
		b. Balance while sitting—position, trunk control	-	=
	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(Code for limitations during last 7 days that interfered with daily funct placed residents at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEME 0. No loss 1. Limitation on one side 1. Limitation on both sides 2. Full loss		or (B)
		a. Neck	()	П
		b. Arm—Including shoulder or elbow c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee	_	
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		
G6.	MODES OF TRANSFER	(Check all that apply during last 7 days)		
	IKANSFER	Bedfast all or most of time Bed rails used for bed mobility NONE OF ABOVE	f.	
67	TACK	or transfer Some or all of ADL activities were broken into subtasks during last 7		
G7.	TASK SEGMENTA- TION			
H1.		SELF-CONTROL CATEGORIES dent's PERFORMANCE OVER ALL SHIFTS)		
		IT—Complete control [includes use of indwelling urinary catheter or os does not leak urine or stool]	stomy	′
		CONTINENT—BLADDER, incontinent episodes once a week or less; s than weekly		
	BOWEL, on		•	
	control pres	TLY INCONTINENT—BLADDER, tended to be incontinent daily, but sent (e.g., on day shift); BOWEL, 2-3 times a week	ome	
_	BOWEL, all	ENT—Had inadequate control BLADDER, multiple daily episodes; (or almost all) of the time		
a.	BOWEL CONTI- NENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	BLADDER CONTI- NENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	1	
H2.	BOWEL ELIMINATION PATTERN	Diarrhea c. NONE OF ABOVE Fecal impaction d.	e.	

H3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling catheter	d.
	AND PROGRAMS			Ostomy present	
		External (condom) catheter	b.	NONE OF ABOVE	i.
Che	ock only those	` '	c.	current ADL status, cognitive state	j.
mod	od and behavior			onitoring, or risk of death. (Do not	
inac	tive diagnoses)	(If none apply, CHECK the N	IONE O	E ABOVE hov	
٠٠٠.	DISEASES	MUSCULOSKELETAL	ONL O	Multiple sclerosis	
			m.	Quadriplegia	w. z.
		NEUROLOGICAL		PSYCHIATRIC/MOOD	
		Aphasia	r.	Depression	ee.
			s.	Manic depressive (bipolar	
		Cerebrovascular accident (stroke)	t.	disease) OTHER	ff.
		Hemiplegia/Hemiparesis	v.	NONE OF ABOVE	rr.
12.	INFECTIONS	(If none apply, CHECK the N	IONE O	F ABOVE box)	
		Antibiotic resistant infection		Septicemia	g.
		(e.g., Methicillin resistant staph)	a.	Sexually transmitted diseases	h.
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
		Conjunctivitis	c.	Urinary tract infection in last 30 days	j.
		HIV infection	d.	Viral hepatitis	k.
		Pneumonia	e.	Wound infection	I.
		Respiratory infection	f.	NONE OF ABOVE	m.
13.	OTHER CURRENT	relationship to current ADL s	tatus, co	osed in the last 90 days that have ognitive status, mood or behavior	
	DIAGNOSES AND ICD-9	medical treatments, nursing n	nonitorin	g, or risk of death)	
	CODES	a.			
		b.		111.	 I I
J1.	PROBLEM		t in last i	7 days unless other time frame is	:
	CONDITIONS	indicated) INDICATORS OF FLUID		OTHER	
		STATUS		Delusions	e.
		Weight gain or loss of 3 or		Edema	g.
		more pounds within a 7 day period	a.	Fever	h.
		Inability to lie flat due to		Hallucinations Internal bleeding	i.
		shortness of breath	b.	Recurrent lung aspirations in	j.
		Dehydrated; output exceeds input		last 90 days	k.
		Insufficient fluid; did NOT	C.	Shortness of breath	l.
		consume all/almost all liquids		Unsteady gait Vomiting	n.
		provided during last 3 days	d.	NONE OF ABOVE	0.
J2.	PAIN	(Code the highest level of pa	ain prese		p.
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain	
		resident complains or		1. Mild pain	
		shows evidence of pain 0. No pain (<i>skip to J4</i>)		2. Moderate pain	
		1. Pain less than daily		3. Times when pain is horrible	
		2. Pain daily		or excrutiating	
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last 180 days	c.
		Fell in past 30 days	a.	-	d.
15	STABILITY	Fell in past 31-180 days	b.	NONE OF ABOVE cognitive, ADL, mood or behavior	e.
J5.	OF	status unstable—(fluctuating, p			a.
	CONDITIONS	Resident experiencing an acu chronic problem	te episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 or fewer	months	to live	c.
		NONE OF ABOVE			d.
K1.	ORAL PROBLEMS	Chewing problem Swallowing problem			a.
	T KOBLEMIO	NONE OF ABOVE			b. d.
K2.	HEIGHT	Record (a.) height in inches	and (b.)	weight in pounds. Base weight	on most
	AND WEIGHT	recent measure in last 30 day standard facility practice—e.g.	/s ; meas ., in a.m.	sure weight consistently in accord after voiding, before meal, with sl	with hoes
		off, and in nightclothes			
K3.	WEIGHT	a.Weight loss—5 % or more		17 (in.) b. WT (lb.) 0 days ; or 10 % or more in last	
NJ.	WEIGHT CHANGE	180 days		- aa, e, or 10 /0 or more in last	
		0. No 1. Yes		0 develor 10 0/	
		b. Weight gain—5 % or more 180 days	ınıast 3	0 days; or 10 % or more in last	
		0. No 1. Yes	3		

K5.	NUTRI-	(Check all that apply i	n last 7 day:	s)					
	TIONAL APPROACH-	Parenteral/IV	a.	On a planned weight change					
	ES	Feeding tube	b.	program	h.				
M1.	ULCERS	(Record the number of u	lcers at each	NONE OF ABOVE ulcer stage—regardless of	i.				
IVI I.	(Due to any cause)	cause. If none present at	t a stage, reco	ord "0" (zero). Code all that apply e.) [Requires full body exam.]	Number at Stage				
	,	skin) that do	es not disapp	edness (without a break in the ear when pressure is relieved.					
		clinically as a	an abrasion, b	skin layers that presents blister, or shallow crater.					
		tissues - pres	ess of skin is id sents as a de j adjacent tiss	ost, exposing the subcutaneous ep crater with or without ue.					
		exposing mu	iscle or bone.						
M2.	TYPE OF ULCER	(For each type of ulcer, c using scale in item M1		highest stage in the last 7 days he; stages 1, 2, 3, 4)					
		Pressure ulcer—any lof underlying tissue	esion caused	by pressure resulting in damage					
		extremities							
M4.	OTHER SKIN PROBLEMS	(Check all that apply du Abrasions, bruises	iring iast 7 d a	nys)	a.				
	OR LESIONS PRESENT	Burns (second or third de	egree)		b.				
	TILOLINI	Open lesions other than	ulcers, rashe	s, cuts (e.g., cancer lesions)	c.				
				g rash, heat rash, herpes zoster	d.				
		Skin desensitized to pair Skin tears or cuts (other t	•		e. f.				
		Surgical wounds	ulaii suigeiy)		g.				
		NONE OF ABOVE			h.				
M5.	SKIN TREAT-	(Check all that apply d	•	ays)					
	MENTS	Pressure relieving device Pressure relieving device	. ,		a. b.				
		Turning/repositioning pro	. ,		C.				
		Nutrition or hydration inte	ervention to m	nanage skin problems	d.				
		Ulcer care	<u>u</u>						
		Surgical wound care f. Application of decesings (with as without topical medications) other than							
		Application of dressings (with or without topical medications) other than of eet							
		Application of ointments		,	h.				
		Other preventative or pro NONE OF ABOVE	otective skin c	are (other than to feet)	j.				
M6.	FOOT	(Check all that apply d	luring last 7 d	lays)	j.				
	PROBLEMS AND CARE			ns—e.g., corns, callouses,					
		Infection of the foot—e.g		es, pain, structural problems rulent drainage	a.				
		Open lesions on the foot		idioni di di di digo	b. c.				
		Nails/calluses trimmed d	luring last 90	days	d.				
		Received preventative o inserts, pads, toe separa		ot care (e.g., used special shoes,	e.				
			,	ut topical medications)	f.				
		Application of dressings (with or without topical medications) NONE OF ABOVE							
N1.	TIME	Check appropriate tim			g.				
	AWAKE	per time period) in the:	ost of time (i.e ————— Even	., naps no more than one hour					
		Morning a Afternoon b		· ·	c. d.				
(If re	esident is co	matose, skip to Sect	,,,,,,	IE OF ABOVE	u.				
N2.	AVERAGE	(When awake and not r	eceiving trea	atments or ADL care)					
		0. Most—more than 2/3		2. Little—less than 1/3 of time					
01.	ACTIVITIES NUMBER OF	1. Some—from 1/3 to 2/3		3. None edications used in the last 7 days ;					
O1.	MEDICA- TIONS	enter "0" if none used)							
	INJECTIONS	the last 7 days; enter "0	" if none used	,					
O4.	DAYS RECEIVED	(Record the number of used. Note—enter "1" fo	r ו טאץ לי dur ing r long-acting ו	g last 7 days ; enter "0" if not meds used less than weekly)					
	THE FOLLOWING	a. Antipsychotic		d. Hypnotic					
	MEDICATION	b. Antianxiety		e. Diuretic					
		c. Antidepressant							

P1.	SPECIAL TREAT-	a. SPECIAL CARE	—Check tr	eatmen	ts or progra	ams receiv	ed du	ring		
	MENTS,	une last 14 days								
	PROCE- DURES, AND	TREATMENTS			Ventilator	or respira	tor		l.	
	PROGRAMS	Chemotherapy		a.	PROGRA	AMS				
		Dialysis		b.	Alcohol/d	rug treatm	ent			
		IV medication		c.	program	r'a/daman	tio one	oial	m.	
		Intake/output		d.	Alzheime care unit	i s/uemen	ilia Spe	ciai	n.	
		Monitoring acute m condition	iedical	e.	Hospice o	care			о.	
		Ostomy care		f.	Pediatric				p.	
		Oxygen therapy		g.	Respite c				q.	
		Radiation		h.	Training in return to					
		Suctioning		i.	taking me work, sho	dications,	house	9	r.	
		Tracheostomy care		j.	ADLs)	ppii ig, tiai	орог	auori,		
		Transfusions		k.		F ABOVE			s.	
		the following the in the last 7 ca [Note—count of (A) = # of days and	p. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a in the last 7 calendar days (Enter 0 if none or less than 15 min. da [Note—count only post admission therapies] A) = # of days administered for 15 minutes or more B) = total # of minutes provided in last 7 days (A) (B)							
		a. Speech - langua					(,,		ŤΠ	
		b. Occupational the	0 .	3,				+	+H	
		c. Physical therapy						+	+H	
		, ,,							+H	
		d. Respiratory then							+	
		 e. Psychological the health profession 		any lice	nsed ment	al				
P3.	NURSING REHABILITA-	Record the NUME restorative technic								
	TION/	more than or equ	ial to 15 m	inutes	per day ir	the last	7 day	'S		
	RESTOR- ATIVE CARE	(Enter 0 if none or a. Range of motion		i o min.	f. Walking				$\overline{}$	
		b. Range of motion	(active)		`	ng or groo	mina			
		c. Splint or brace as	ssistance		h. Eating		•			
		TRAINING AND S	KILL			ation/prost	•	care		
		d. Bed mobility			j. Commi	•				
		e. Transfer			k. Other					
P4.	DEVICES	Use the following of 0. Not used	codes for la	ast 7 da	ys:					
	AND RESTRAINTS	1. Used less than	daily							
		Used daily Bed rails							-	
		a. — Full bed rails	s on all oper	n sides o	of bed					
		b. — Other types				I, one side	e)			
		c. Trunk restraint					•			
		d. Limb restraint								
		e. Chair prevents ris							\perp	
P7.	PHYSICIAN VISITS	In the LAST 14 DA facility) how many of practitioner) examined	days has the	e physic	ian (or auth	norized as		t or		
P8.	PHYSICIAN	In the LAST 14 DA								
	ORDERS	facility) how many of practitioner) change renewals without co	ed the resid	lent's ord	ders? Do n					
Q2.	OVERALL	Resident's overall le								
	CHANGE IN CARE NEEDS	compared to status than 90 days)	-	•						
		0. No change 1. In	nproved—re upports, nee			eteriorate nore suppo		ceives	>	
		re	strictive lev	el of car	е					
R2.	SIGNATURE	S OF PERSONS	COMPLET	ING TH	IE ASSES	SSMENT:				
	•	Assessment Coordin	nator (sign o	on above	e line)					
	ate RN Assessi gned as comple	ment Coordinator ete	Month .		Day —	Y	éar			
c. O	ther Signatures			Title	;	Sections			Date	
d.									Date	
e.									Date	
f.									Date	
g.									Date	
h.									Date	

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG-III 1997 Update)

A1.	RESIDENT	IONAL	LINOIN	JIV 1 C	, i i i i i	O-III	1331	Opuato	,	
	NAME									
A2.	ROOM	a. (First)		b. (Middl	e Initial)		c. (Las	t) (d. (Jr/Sr)	
	NUMBER									
А3.	ASSESS- MENT	a. Last day o	f MDS obs	servation	period			_		
	REFERENCE DATE									
	DAIL	Mo	nth	Day		Yea	ar			
A 4-	DATE OF	b. Original (0	<u> </u>							
A4a.	DATE OF REENTRY	Date of ree last 90 days								
		Mont	_][Day		 Year				
A6.	MEDICAL	I IVIORIE		Day		1 1				
	RECORD NO.									
B1.	COMATOSE	(Persistent v	egetative s	state/no o			ousnes:			
B2.	MEMORY	(Recall of wh	at was lea	rned or k	,			,		
		a. Short-terr 0. Memor			ems/appe		ecall afte	er 5 minutes	;	
			Long-term memory OK—seems/appears to recall long past							
B3.	MEMORY/	0. Memor	,		, ı		call dur	ina		
	RECALL ABILITY	last 7 days) Current seas						J		
	712.2	Location of o		a. b.	That he	she is ir	n a nursi	ng home	d.	
	0000	Staff names		c.	NONE		VE are	ecalled	e.	
B4.	SKILLS FOR	(Made decis		Ū	•	,				
	DAILY DECISION-	0. INDEPEN 1. MODIFIE						situations		
	MAKING	only 2. MODERA	ATELY IMP	AIRED-	-decisions	s poor; c	ues/sup	ervision		
		required 3. SEVERE								
B5.	OF	(Code for be requires co	nversatio	ns with s	staff and					
	DELIRIUM— PERIODIC	of resident's 0. Behavior			ıs tıme].					
	DISOR- DERED	Behavior Behavior Behavior	present, no	ot of rece		ears diff	erent fro	ım resident	מופוו פ'	
	THINKING/ AWARENESS	functionin	g (e.g., ne	w onset c	r worseni	ing)			- I	
		a. EASILY D		ED(e.(g., difficult	y payınç	gattentic	n; gets		
		b.PERIODS	OF ALTE							
		present; b	elieves he	/she is so	mewher	e else; c	onfuses	night and		
		c. EPISODE	S OF DIS	ORGAN	IZED SPI	EECH-	-(e.g., sp	eech is		
			nt, nonsens ses train c			ramblino	g from su	ubject to		
		d.PERIODS						icking at sk itive physic		
			nts or callin		nt positioi	Toriang	53, Tepel	iuve priyaic	ai	
		e. PERIODS difficult to	OF LETH arouse; litt				ess; stari	ng into spa	ce;	
		f. MENTAL								
	111/01/0		g., sometir es present,	sometim	ies not)			aviois		
C4.	MAKING SELF	0. UNDERS		on conten	ı—nowev	rei abie)				
	UNDER- STOOD	1. USUALLY thoughts	'UNDERS	STOOD-	-difficulty	finding \	words or	finishing		
		2. SOMETIM requests				y is limit	ed to ma	king concr	ete	
C6.	ABILITYTO	3. RARELY/ (Understand				nt—how	vever abi	'e)		
	UNDER- STAND	0. UNDERS	STANDS					,		
	OTHERS	1. USUALLY message			•					
		2. SOMETII direct com 3. RARELY/	nmunicatio	n		ou ius a	uequale	у ю ыпріе	,	
E1.	INDICATORS	(Code for in	ndicators			30 days	, irrespe	ective of th	е	
	OF DEPRES-	0. Indicator	not exhibit			o de e	a week			
	SION, ANXIETY,	Indicator Indicator						7 days a we	eek)	
	SAD MOOD									

	Numeric Ident	mer						
E1.	INDICATORS OF DEPRES- SION, ANXIETY, SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Residements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die,	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE I. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or					
		he or she is about to die, have a heart attack	long standing activities or being with family/friends					
			p. Reduced social interaction					
E2.	MOOD PERSIS- TENCE	One or more indicators of depress not easily altered by attempts to " the resident over last 7 days 0. No mood 1. Indicators present indicators easily altered	t, 2. Indicators present,					
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequenc 0. Behavior not exhibited in last 7 1. Behavior of this type occurred 2. Behavior of this type occurred 3. Behavior of this type occurred	days 1 to 3 days in last 7 days 4 to 6 days, but less than daily					
		 (B) Behavioral symptom alterabilin 0. Behavior not present OR beha 1. Behavior was not easily altered a. WANDERING (moved with no ra oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIO 	vior was easily altered to the control of the contr) (B)				
		were threatened, screamed at, ct c. PHYSICALLY ABUSIVE BEHAV were hit, shoved, scratched, sexu	ursed at) IORAL SYMPTOMS (others					
		d. SOCIALLY INAPPROPRIATE/DI SYMPTOMS (made disruptive so self-abusive acts, sexual behavio smeared/threw food/feces, hoard belongings)	SRUPTIVE BEHAVIORAL bunds, noisiness, screaming, r or disrobing in public,					
		e. RESISTS CARE (resisted taking assistance, or eating)	medications/ injections, ADL					
G1.		F-PERFORMANCE—(<i>Code</i> for residuring last 7 days—Not including set		L				
		DENT—No help or oversight —OR—	• •	2 time:				
	last7 days 1 or 2 time	SION—Oversight, encouragement o —OR— Supervision (3 or more time s during last 7 days	es) plus physical assistance provide	ed only				
	guided ma OR—More	ASSISTANCE—Resident highly involue neuvering of limbs or other nonweight help provided only 1 or 2 times duri	nt bearing assistance 3 or more time ng last 7 days	ės—				
	period, hel —Weight- — Full staf	VE ASSISTANCE—While resident pop of following type(s) provided 3 or mobearing support formance during part (but not all	ore times: I) of last 7 days	-аау				
		EPENDENCE—Full staff performance of activity during entire 7 days OID NOT OCCUR during entire 7 days						
			~y -					
	(B) ADL SUPP OVER ALL	PORT PROVIDED—(Code for MOS . SHIFTS during last 7 days; code to conclusion (Code for MOS)		A) (B)				
	(B) ADL SUPF OVER ALL performand 0. No setup o 1. Setup help	. SHIFTS during last 7 days; code of classification) r physical help from staff only	regardless of resident's self-					
	(B) ADL SUPF OVER ALL performance 0. No setup o 1. Setup help 2. One person 3. Two+ person	. SHIFTS during last 7 days; code to classification) r physical help from staff only n physical assist sons physical assist	regardless of resident's self- () () () () () () () () () (SUPPORT (8)				
a.	(B) ADL SUPF OVER ALL performance 0. No setup o 1. Setup help 2. One person	. SHIFTS during last 7 days; code to classification) r physical help from staff only n physical assist	Regardless of resident's self- B. ADL activity itself did not occur during entire 7 days and position, turns side to side,					

G1.					(A)	(B)			
C.	WALK IN ROOM	How resident walks between lo	ocations	in his/her room					
d.	WALK IN CORRIDOR	How resident walks in corridor	on unit						
e.	LOCOMO- TION ON UNIT	How resident moves between adjacent corridor on same floo once in chair							
f.	LOCOMO- TION OFF UNIT	How resident moves to and ret areas set aside for dining, activ only one floor , how resident n the floor. If in wheelchair, self-s	rities, or noves to	treatments). If facility has and from distant areas on					
g.	DRESSING	How resident puts on, fastens, clothing, including donning/re	moving	prosthesis					
h.	EATING	How resident eats and drinks (nourishment by other means (nutrition)							
i.	TOILET USE	How resident uses the toilet root transfer on/off toilet, cleanses, catheter, adjusts clothes							
j.	PERSONAL HYGIENE	brushing teeth, shaving, applyi	w resident maintains personal hygiene, including combing hair, ıshing teeth, shaving, applying makeup, washing/drying face, nds, and perineum (EXCLUDE baths and showers)						
G2.	BATHING	transfers in/out of tub/shower (Code for most dependent in	ow resident takes full-body bath/shower, sponge bath, and insfers in/out of tub/shower (EXCLUDE washing of back and hair.) ode for most dependent in self-performance. BATHING SELF PERFORMANCE codes appear below						
		0. Independent—No help pro			Г				
		 Supervision—Oversight heads. Physical help limited to train 		h.					
		 Physical help limited to tra Physical help in part of bat 		•					
		Total dependence	i iii ig ao	ivity					
		8. Activity itself did not occur	during e	entire 7 days					
G3.	TEST FOR	(Code for ability during test in t	he last	7 days)					
	BALANCE	0. Maintained position as requ	ired in te	est					
	(see training	 Unsteady, but able to rebala Partial physical support duri 		without physical support					
	manual)	or stands (sits) but does not	follow d	irections for test					
		 Not able to attempt test with a. Balance while standing 	out pnys	sicai neip	Т	-			
		b. Balance while sitting—positi	ion. trun	k control	H	\dashv			
G4.	FUNCTIONAL	(Code for limitations during las	t 7 days		ions	or			
	LIMITATION IN RANGE OF	placed residents at risk of injur (A) RANGE OF MOTION	y)	(B) VOLUNTARY MOVEME	NT				
	MOTION	No limitation		Ò. No loss	• 1				
		Limitation on one side Limitation on both sides		 Partial loss Full loss 	(A)	(B)			
		a. Neck							
		b. Arm—Including shoulder or	elbow						
		c. Hand—Including wrist or fine	gers						
		d. Leg—Including hip or knee							
		e. Foot—Including ankle or toe	S						
		f. Other limitation or loss	47-1-	\					
G6.	MODES OF TRANSFER	(Check all that apply during la	151 / Ua	, i					
		Bedfast all or most of time	a.	NONE OF ABOVE	f.				
		Bed rails used for bed mobility or transfer	b.						
G7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	rform th						
H1.		SELF-CONTROL CATEGOR dent's PERFORMANCE OVE		SHIFTS)	_				
		T—Complete control [includes does not leak urine or stool]	use of ii	ndwelling urinary catheter or os	stomy	<i>'</i>			
	BOWEL, les	CONTINENT—BLADDER, inco is than weekly							
	BOWEL, on				•				
	control pres	TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,	2-3 tim	es a week	ome				
		ENT—Had inadequate control E (or almost all) of the time	SLADDE	:r., muitipie daily episodes;					
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appli	ance or bowel continence					
b.	BLADDER CONTI- NENCE	Control of urinary bladder functions soak through underpants), with programs, if employed							
H2.	BOWEL	Diarrhea	c.	NONE OF ABOVE	e.	\Box			
	ELIMINATION PATTERN	Fecal impaction	d.		0.				

Н3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling catheter	d.
	AND PROGRAMS	Bladder retraining program	b.	Ostomy present	i.
		External (condom) catheter		NONE OF ABOVE	i.
				current ADL status, cognitive stat	
	id and behavior tive diagnoses)	status, medical treatments, nu	rsing mo	onitoring, or risk of death. (Do not	list
11.	DISEASES	(If none apply, CHECK the N	ONE O	F ABOVE box)	
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Diabetes mellitus	a.	Multiple sclerosis	w.
		MUSCULOSKELETAL	u.	Quadriplegia PSYCHIATRIC/MOOD	Z.
		Hip fracture	m.	Depression	
		NEUROLOGICAL		Manic depressive (bipolar	ee.
		Aphasia	r.	disease)	ff.
		Cerebral palsy Cerebrovascular accident	S.	OTHER NONE OF ABOVE	
		(stroke)	t.		rr.
12.	INFECTIONS	(If none apply, CHECK the N	ONE O	•	
		Antibiotic resistant infection (e.g., Methicillin resistant		Septicemia	g.
		staph)	a.	Sexually transmitted diseases Tuberculosis	h.
		Clostridium difficile (c. diff.)	b.	Urinary tract infection in last 30	i.
		Conjunctivitis	c.	days	j.
		HIV infection	d.	Viral hepatitis	k.
		Pneumonia Respiratory infection	e.	Wound infection NONE OF ABOVE	l.
I3.	OTHER	(Include only those diseases	f. diagno	osed in the last 90 days that ha	m. ve a
	CURRENT	relationship to current ADL s medical treatments, nursing n		ognitive status, mood or behavior a. or risk of death)	status,
	AND ICD-9	modical a cauncino, naicing n		g, c. ne.c. deda.,	
	CODES	a		•	
		b.			
J1.	PROBLEM CONDITIONS	(Check all problems presen indicated)	t in las t i	7 days unless other time frame is	;
		INDICATORS OF FLUID		OTHER	
		STATUS		Delusions	e.
		Weight gain or loss of 3 or more pounds within a 7 day		Edema Fever	g. h.
		period	a.	Hallucinations	i.
		Inability to lie flat due to shortness of breath		Internal bleeding	j.
		Dehydrated; output exceeds	b.	Recurrent lung aspirations in	
		input	c.	last 90 days Shortness of breath	k. I.
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.
		provided during last 3 days	d.	Vomiting	о.
		(0.1.4.1.1.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.		NONE OF ABOVE	p.
J2.	PAIN SYMPTOMS	(Code the highest level of pa	ı ın prese		
		a. FREQUENCY with which resident complains or		b. INTENSITY of pain1. Mild pain	
		shows evidence of pain		2. Moderate pain	
		0. No pain (<i>skip to J4</i>) 1. Pain less than daily		3. Times when pain is horrible	
		2. Pain daily		or excrutiating	
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last 180 days	c.
		Fell in past 30 days	a.	Other fracture in last 180 days	d.
-	OTA DIL ITY	Fell in past 31-180 days	b.	NONE OF ABOVE cognitive, ADL, mood or behavior	e.
J5.	STABILITY OF	status unstable—(fluctuating,			a.
	CONDITIONS	Resident experiencing an acu chronic problem	te episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 or fewer	months	to live	c.
		NONE OF ABOVE	1110111110	10 HVO	d.
K1.	ORAL	Chewing problem			a.
	PROBLEMS	Swallowing problem NONE OF ABOVE			b.
K2.	HEIGHT		and (b.)	weight in pounds. Base weight	d. on mos
	AND WEIGHT	recent measure in last 30 day	's ; meás	sure weight consistently in accord after voiding, before meal, with s	l with
	WEIGHT	off, and in nightclothes	,	The relating, below mean, mare	
				HT (in.) b. WT (lb.)	
K3.	WEIGHT CHANGE	a.Weight loss—5 % or more 180 days	ın l ast 3	0 days; or 10 % or more in last	
		0. No 1. Yes			
		b. Weight gain—5 % or more 180 days	in last 3	0 days; or 10 % or more in last	
		0. No 1. Yes	6		

Numeric	Identifier

K5.	NUTRI-	(Check all that apply in last	t 7 days)		P1.		a. SPECIAL CARE—Check to	reatmen	nts or programs recei	ved du	ıring		
	TIONAL APPROACH-	Parenteral/IV	a.	On a planned weight change			TREAT- MENTS,	the last 14 days						
	ES	Feeding tube	b.	program	h.		PROCE-	TREATMENTS		Ventilator or respira	ator			_
		(Skip to Section M if neither	Fa mar F	NONE OF ABOVE	i.		DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			1.	
K6.	PARENTERAL OR ENTERAL	a. Code the proportion of total	oa nor o	b is criecked)				Dialysis	b.	Alcohol/drug treatr	nent			
	INTAKE	parenteral or tube feedings i	n the las	at / days				IV medication	c.	program			m.	
		0. None 1. 1% to 25%		. 51% to 75% . 76% to 100%				Intake/output	d.	Alzheimer's/deme	ntia sp	ecial		
		2. 26% to 50%	7.	. 7070 10 10070				Monitoring acute medical		care unit			n. o.	_
		b. Code the average fluid inta						condition	e.	Hospice care Pediatric unit			p.	_
		0. None 1. 1 to 500 cc/day		. 1001 to 1500 cc/day . 1501 to 2000 cc/day				Ostomy care	f.	Respite care			a.	_
		2.501 to 1000 cc/day		2001 or more cc/day				Oxygen therapy	g.	Training in skills re	auired	to		
M1.	ULCERS	(Record the number of ulcers a		licer stage—regardless of rd "0" (zero). Code all that apply	Number at Stage			Radiation	h.	return to the comn	nunity	(e.g.,		
	(Due to any			a 0 (2010). Code all trial apply .) [Requires full body exam.]	ᄣᇸ			Suctioning	i.	taking medications work, shopping, tra			r. 1,	
	cause)	a. Stage 1. A persistent area of			2 %			Tracheostomy care Transfusions	j. k	ADLs) NONE OF ABOVE	Ē			
		b. Stage 2. A partial thickness	loss of s					b.THERAPIES - Record the the following therapies wa						
		c. Stage 3. A full thickness of	skin is lo	ister, or shallow crater. st, exposing the subcutaneous p crater with or without				in the last 7 calendar da [Note—count only post (A) = # of days administere	<i>ys (Ente</i> admiss	er 0 if none or less t sion therapies]		5 mi		
		undermining adjac						(B) = total # of minutes pro			(A)		(B)	
		d. Stage 4. A full thickness of sexposing muscle of		subcutaneous tissue is lost,				a. Speech - language patholo	ogy and	audiology services	·			
M2.	TYPE OF	(For each type of ulcer, code t	or the h	ighest stage in the last 7 days				b. Occupational therapy				Н		L
	ULCER	using scale in item M1—i.e. a. Pressure ulcer—any lesion		e; stages 1, 2, 3, 4) by pressure resulting in damage				c. Physical therapy d. Respiratory therapy			-	\vdash		\vdash
		of underlying tissue		.,,				e. Psychological therapy (by	any lice	nsed mental		H		\vdash
		b. Stasis ulcer—open lesion ca extremities	aused by	poor circulation in the lower		P3.	NURSING	health professional) Record the NUMBER OF DA			ehahil	itatio	n or	
M4.	OTHER SKIN	Abrasions, bruises			a.	3.	REHABILITA-	restorative techniques or pra	ictices i	was provided to th	e resi	dent	for	
	OR LESIONS	Burns (second or third degree)			b.		TION/ RESTOR-	more than or equal to 15 n (Enter 0 if none or less than			r / da	ys		
	PRESENT	Open lesions other than ulcers		rash, heat rash, herpes zoster	c. d.		ATIVE CARE	a. Range of motion (passive)		f. Walking				
	(Check all	Skin desensitized to pain or pro		rash, neatrash, nerpes zoster				b. Range of motion (active)		g. Dressing or groo	ming			
	that apply during last 7	Skin tears or cuts (other than s			e. f.			c. Splint or brace assistance		h. Eating or swallow	wing			
	days)	Surgical wounds	3- 77		g.			TRAINING AND SKILL PRACTICE IN:		i. Amputation/pros	thesis	care	. —	
		NONE OF ABOVE			h.			d. Bed mobility		j Communication				_
M5.	SKIN	Pressure relieving device(s) fo			a.			e. Transfer		k. Other				_
	TREAT- MENTS	Pressure relieving device(s) fo			b.	P4.	DEVICES	Use the following codes for I	ast 7 d	ays:				
	_													
	(Chook all	Turning/repositioning program		anaga akin problema	C.		AND RESTRAINTS	Not used Used less than daily						
	(Check all that apply	Nutrition or hydration intervent		anage skin problems	c. d.		RESTRAINTS	Used less than daily Used daily						
	that apply during last 7	Nutrition or hydration intervent Ulcer care		anage skin problems	c. d. e.		RESTRAINTS	Used less than daily Used daily Bed rails	n sidos	of bod				
	that apply	Nutrition or hydration intervent Ulcer care Surgical wound care	ion to ma	·	c. d. e. f.		RESTRAINTS	Used less than daily Used daily Bed rails Full bed rails on all operations.			۵)			
	that apply during last 7	Nutrition or hydration intervent Ulcer care Surgical wound care Application of dressings (with of to feet	ion to ma	it topical medications) other than	c. d. e. f.		RESTRAINTS	Used less than daily Used daily Bed rails			e)			
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Date Date Date Date Date

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME®									
		a. (First)		b. (Midd	e Initial)		c. (L	.ast)	d. (Jr	/Sr)
2.	GENDER®	1. Male		2. Fe	male					
3.	BIRTHDATE®									
		L Mo	l onth	Dav		Щ,	ear			
4.	RACE/			Alaskan N	ativo		4. Hisp	anic		
٦٠	ETHNICITY®		Pacific Isla		auve			te, not o	f	
		3. Black, r	not of Hisp	anic origin				panic or		
5.	SOCIAL	a. Social	Security N	lumber						
	SECURITY® AND		-	_	1_					
	MEDICARE			, L	┦.	إلىا		Ш.	,	
	NUMBERS €	b. Medica	ire numbe	r (or compa	arabie ra	iiiroad	insurance	e numbe	er)	
	[C in 1st box if									
	non med. no.]									
6.	FACILITY	a. State N	lo.							
	PROVIDER NO.®									
	NO.€									
		b. Federa	l No							
7.	MEDICAID									
	NO. ["+" if pending, "N*"		1 1		- 1		1 1			- I
	pending, N									
	Medicaid			_	_ ! _ !	!_				_
	recipient] €									
8.		[Note—O	ther codes	do not ap	ply to thi	s form]			
	FOR ASSESS-	a. Primar	v reason fo	or assessn	nent					
	ASSESS- MENT									
				return not a eturn antic		ed				
				ior to comp		itial as	sessmen	t		
9	SIGNATURE							-		
٠.	0.0.0	00. 0.,								
a. Si	gnatures				Title		Sect	ons		Date
u. 0.	griataroo				1100		0000	0110		Date
b.										Date
_										
C.										Date

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE	a. Code for resident disposition upon discharge							
	STATUS	Private home/apartment with no home health services							
		Private home/apartment with home health services							
		3. Board and care/assisted living							
		4. Another nursing facility							
		5. Acute care hospital							
		6. Psychiatric hopital, MR/DD facility							
		7. Rehabilitation hospital							
		8. Deceased							
		9. Other							
		b. Optional State Code							
4.		Date of death or discharge							
	DATE	Month Day Year							
		Month Day Year							

SECTION AB. DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] (AA8a=8)

1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use pradmission date								
		Month Day Year								
2.	ADMITTED FROM (AT ENTRY)	Private home/apt. with no home health services Private home/apt. with home health services Board and care/assisted living/group home								
	,	4. Nursing home								
		5. Acute care hospital								
		Psychiatric hospital, MR/DD facility Rehabilitation hospital								
		8. Other								

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

-	MEDICAL									
Ю.	MEDICAL			ı	l	l	l			
	RECORD				l	l	l			
	NO			ı	l	l	l			
	INO.	 		•	•	•	•	•	•	

*	= Key	items f	for	computerized	resident	tracking
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REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

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2. GENDER® 1. Male 2. Female 3. BIRTHDATE®	1.																	
3. BIRTHDATE® Month Day Year 4. RACE/ ETHNICITY® 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. White, not of 3. Black, not of Hispanic origin Hispanic origin 5. SOCIAL SECURITY® AND MEDICARE 0. Medicare number (or comparable railroad insurance number) [C in 1st box if non med. no.] 6. FACILITY a. State No. PROVIDER NO. "** if not a Medicaid recipient] ® b. Federal No. Medicaid recipient] ® a. Primary reason for assessment 9. Reentry 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date			a. (F	irst)		ŀ). (Mi	ddle Ir	nitial)		(:. (La	ast)		d.	. (Jr/	Sr)
4. RACE/ ETHNICITY © 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic origin 5. White, not of Hispanic origin 4. Hispanic origin 5. SOCIAL AND MEDICARE NUMBERS © IC in 1st box if non med. no.] 6. FACILITY PROVIDER NO. PROVIDER NO. ['+" if pending, "N" if not a Medicaid recipient] © No. ['+" if pending, "N" if not a Medicaid recipient] © No. Penderal No. [No. Penderal No. In the composition of the composition	2.	GENDER®	1. Ma	ale			2.	Fema	le									
ETHNICITY® 3. Black, not of Hispanic origin 5. White, not of Hispanic origin a. Social Security Number Security AND MEDICARE NUMBERS® [C in 1st box if non med. no.] b. Medicare number (or comparable railroad insurance number) 6. FACILITY PROVIDER NO.® 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ® 8. REASONS FOR ASSESSMENT 9. Reentry 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date	3.	BIRTHDATE®		Mon	th	-[Day		_		Ye	ar						
SECURITY AND MEDICARE NUMBERS 0 [C in 1* box if non med. no.] 6. FACILITY PROVIDER NO. b. Federal No. 7. MEDICAID NO. ["4" if pending,"N" if not a Medicaid recipient[0] 8. REASONS FOR ASSESS- MENT 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date		ETHNICITY ®	2. As 3. Bla	2. Asian/Pacific Islander 5. White, not of														
PROVIDER NO.® b. Federal No. 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] © 8. REASONS FOR ASSESSMENT 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date b. Date	5.	SECURITY® AND MEDICARE NUMBERS® [C in 1st box if]_		npara	ble r	ailro	ad ir	nsura	ance	nun	nber)		
NO. © b. Federal No. 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] © 8. REASONS FOR ASSESSMENT 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date	6.		a. St	ate No														
7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] © 8. REASONS FOR ASSESSMENT 9. Reentry 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date		NO.®																
NO. ["+" if pending, "N" if not a Medicaid recipient] © 8. REASONS FOR ASSESSMENT 9. Rentry 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date			b. Fe	deral N	No.													
FOR ASSESS-MENT a. Primary reason for assessment 9. Reentry 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date	7.	NO. ["+" if pending, "N" if not a Medicaid																
ASSESS-MENT 9. Reentry 9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date	8.	REASONS	[Note	-Oth	er co	des de	o not	apply	to th	nis fo	rm]							
9. SIGNATURES OF PERSONS COMPLETING FORM a. Signatures Title Sections Date b. Date		ASSESS-		,		n for a	asses	smen	t									
a. Signatures Title Sections Date b. Date	_				•		MADI	-TIN	~ -	<u> </u>								
b. Date	9.	SIGNATURE	5 UF	PEK	SUN	5 60	WIPL	EIIN	GF	UKI	VI							
	a. S	ignatures						Titl	е			S	ectic	ns				Date
c. Date	b.																	Date
	C.																	Date

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

_													
4a.	DATE OF	Date of reentry											
	REENTRY	Month Day Year											
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other											
6.	MEDICAL RECORD												

 $^{\scriptsize{\textcircled{3}}}$ = Key items for computerized resident tracking

= When box blank, must enter number or letter a. = When letter in box, check if condition applies